ORTHOPAEDIC ASSOCIATES
The Strength of Experience

Patient Registration Form

Today's Date: _____

Patient Last Name: _____ First: _____MI: _____ Sex: ☐ M ☐ F

Guardian (If Applicable): _____

Social Security #: _____ - _____ -_____ Birthdate: _____ E-mail:_____

Address: _____ City: _____State: ____ Zip Code: _____

Mailing Address (If different):_____ City: _____State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____Ext:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Work Status**: ☐ Employed ☐ Retired ☐ Unemployed ☐ Student

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Caucasian ☐ African American ☐ American Indian/Alaskan Native

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Primary Language**: ☐ English ☐ Other: _____

Primary Insurance: _____ Policy Number: _____

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____ - _____ -_____

Employer (if applicable):_____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance: _____ Policy Number: _____

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____ - _____ -_____

Employer (if applicable):_____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Tertiary Insurance: _____ Policy Number: _____

Subscriber Name: _____Subscriber DOB: _____Subscriber SS#: _____ - _____ -_____

Employer (if applicable):_____ Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

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Are you here due to an automobile accident? ☐ Yes ☐ No If yes, please indicate auto insurance: _____

Are you here due to a work accident? ☐ Yes ☐ No If yes, please indicate worker's comp carrier: _____

Do you currently reside in a nursing home? ☐ Yes ☐ No If yes, please indicate name: _____

Preferred Pharmacy: _____ Phone: _____

Primary Care Physician: _____ Referring Physician (If applicable):_____

Emergency Contact: _____ Relation: _____ Phone: _____

ORTHOPAEDIC ASSOCIATES

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____
Age: _____ **Sex:** ○ M ○ F **Height:** _____ **Weight:** _____
Race: _____ **Ethnicity:** _____ **Preferred Language:** _____
Referring Physicians Name: _____
Part of the body being seen for today: ○ R ○ L ○ BIL (both) _____

In this section, check the box which best describes how your problem started. Please answer the questions related to the box you checked.

	Description of Injury / Accident
○ **NO INJURY** Was the onset ○ Gradual ○ Sudden Onset Date: _____	
○ **INJURY** ○ Accident ○ Sport Date: _____	
○ **INJURY AT WORK** Date: _____ ○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive	
○ **AUTO ACCIDENT** Date: _____	

Have you had a problem like this before? ○ N ○ Y

Were you seen in the E.R. for this problem? ○ N ○ Y Which E.R.? _____

What test scans have you had for this problem?
○ X-rays ○ MRI ○ CAT Scan ○ Bone Scan ○ Nerve Test (EMG / NCV)

On a scale of 0-10 (10 is the worst) how severe is your pain? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What is the quality of pain? ○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning

The pain is ○ Constant ○ Intermittent (comes & goes) Does the pain wake you from your sleep? ○ N ○ Y

I experience: ○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness ○ Loss of control of bowel or bladder
○ Locking / Catching ○ Giving way ○ Pain ○ Stiffness Other _____

Since my problem started, it is: ○ Getting Better ○ Getting worse ○ Unchanged

What makes your symptoms worse: ○ Standing ○ Walking ○ Lifting ○ Twisting ○ Bending ○ Stairs ○ Exercise
○ Squatting ○ Kneeling ○ Sitting ○ Coughing ○ Sneezing ○ Bending ○ Lying in bed

What makes your symptoms better?: ○ Rest ○ Elevation ○ Ice ○ Heat Other: _____

PAST MEDICAL HISTORY

List all previous surgeries : ○ None

	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any medications you are taking on a regular basis (including hormonal replacement therapy or birth control):

○ None	Medication	Reason
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Patient Name: _____

PAST MEDICAL HISTORY

Are you allergic to any medications? ○ N ○ Y If Yes, please list below:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Other Allergies? (ex. latex, IV contrast, shellfish) Please specify: _____

Do you have a personal history or any of the following? ○ NONE

○ Excessive or Prolonged Bleeding	○ Rheumatic Fever	○ HIV / AIDS	○ Stroke
○ Blood Clots	○ Diabetes Type: _____		○ Circulatory Problems
○ Asthma	○ Reaction to Anesthesia Type: _____		○ Heart Disease / Defect
○ Stomach Ulcers	○ Cancer Type: _____		○ Chemotherapy / Radiation
○ Birth Defects	○ Arthritis Type: _____		○ Continuous Seizures
○ Problems with Wounds Healing	○ Hepatitis	○ Fractures / Joint Dislocations	○ Epilepsy
○ Emphysema	○ Bone or Joint Infections	○ Tuberculosis	○ Lung Disease
Are you Pregnant? ○ N ○ Y	○ Abnormal Blood Pressure	○ Chemical Dependency	○ Psychiatric Care
Claustrophobic? ○ N ○ Y	○ Pacemaker	○ Sleep Apnea	Use a C PAP? ○ N ○ Y

REVIEW OF SYSTEMS

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					NONE	COMMENTS
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	_____
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?

FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis

SOCIAL HISTORY

Do you use tobacco? ○ N ○ Y If Yes, packs per day _____ ○ Quit **Informed of Smoking Risk?** ○ N ○ Y
Alcohol use? ○ N ○ Y ○ Quit
Marital History: ○ Married ○ Single ○ Divorced ○ Widowed
Are you currently working? ○ Y ○ N ○ Retired ○ Disabled If no, when did you last work? _____
Are you currently on any work restrictions? ○ N ○ Y If Yes, what are they? _____
Occupation: _____ **Employer:** _____ ○ **Student**

_____ _____
Signature **Date**

ORTHOPAEDIC ASSOCIATES
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554-D Twin Cities Boulevard
Niceville, FL 32578
850-863-2153

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536
850-863-2153

Panama City
1827 Harrison Avenue
Panama City, FL 32405
(850) 785-4344

Authorization to Release Medical Information

Patient Name: _____ DOB: _____

I hereby give my authorization and permission for the following members (other than legal guardian) to speak with my physician(s) at Orthopaedic Associates concerning my medical condition.

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

I understand that I have the right to revoke this authorization at any time.
I understand that if I revoke this authorization I must do it in writing.
I understand that this authorization will expire in two (2) years from the date signed.

_____ _____
Signature Date

FINANCIAL PAYMENT POLICY

ORTHOPAEDIC ASSOCIATES
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1. **REGARDING INSURANCE:** The physician's service is provided directly to you and you are responsible for payment of services rendered. Our office participates with Medicare and many other insurance companies. Should your insurance coverage be with one or more of these companies we will, as a courtesy to you, bill your insurance along the guidelines of our contract. However co-payment, deductibles, and non-covered charges are the responsibility of the patient and payment is expected at the time services are rendered. Also, any charges denied by insurance as a result of patient failure to obtain appropriate authorization/referral as part of a managed care plan are the responsibility of the patient and payment is expected at the time services are rendered.

2. **SPECIAL ARRANGEMENTS:** There are times when making payments can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our billing department as soon as possible. I understand that I accept full financial responsibility in the event that the insurance information I have provided is no longer valid, active, or accepted by Orthopaedic Associates.

3. **COLLECTION FEES:** In consideration of the services to be rendered to the patient, I individually promise, whether signing as the patient, patient's agent, or as guarantor, to pay the account of Orthopaedic Associates not later than the time treatment is rendered, unless specific account payment arrangements have been previously approved by Orthopaedic Associates. Should the account be referred to an attorney or other third party collections, the undersigned shall pay reasonable attorney fees, third party collection fees and collection expenses. I waive notice of demand as a prerequisite to the commencement of legal proceedings for medical charges. No delay or omission by the hospital shall be considered a waiver of any right. I agree that venue in any action brought against me for medical charges shall be in Bay County, Florida. The law prescribes all delinquent accounts bear interest at the highest legal rate or in the event no maximum rate, at eighteen percent (18%) per annum.

Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please contact our billing department.

I hereby understand the financial policy of this office: _____
PATIENT NAME (Please Print)

_____ _____
PATIENT or LEGAL GUARDIAN'S SIGNATURE DATE

INSURANCE AUTHORIZATION

(Please sign if we are filing any insurance company on your behalf)

I request that payment of authorized insurance benefits be made on my behalf to the provider for any services furnished to me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim(s). If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms of electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non- covered services. Coinsurance and the deductible are based upon the charge determination of the insurance companies.

_____ _____
PATIENT or LEGAL GUARDIAN'S NAME (PRINT) PATIENT or LEGAL GUARDIAN'S SIGNATURE

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1827 Harrison Avenue | Panama City, FL 32405

PATIENT INFORMATION

1. **INTRODUCTION**

Welcome to Orthopaedic Associates. This pamphlet provides information that we hope will foster a pleasant and effective relationship between patient and physician and contribute to better understanding of how to serve you, the patient. If you have further questions, please do not hesitate to ask any member of our staff.

2. **APPOINTMENTS**

A. If you are unable to keep your appointment please call the office and cancel it at least 24 hours in advance.

B. The physicians and staff work hard to see patients on time. If you have to wait to be seen it is for an unavoidable reason. We are obliged to see emergencies and patients referred on an urgent basis by other physicians. Some patients require an unexpected amount of time due to unforeseen complications or problems. For these reasons, we are occasionally behind schedule. We ask for your understanding in those situations.

C. Please complete the information sheet and medical history forms and bring it with you at the time of your first visit.

3. **CHARGES**

A. Charges made for surgical procedures cover post-op office visits for a period of time determined by your insurance company, varying from 7 to 90 days. The surgery charges do not cover x-rays or cast changes made relative to the surgery.

B. Charges for fracture treatment cover all office visits related to the fracture for a period of time determined by your insurance company, varying from 7 to 90 days. The fracture charges do not cover x-rays or cast changes.

C. If it is determined that you are going to need to have surgery, our office will call your insurance company to determine what portion of the surgery your insurance will cover. Someone from our insurance department will then contact you and inform you of approximately how much you will owe the physician. Patients will be expected to pay their portion of an elective surgery prior to it being performed. Self-pay patients will also be responsible for paying a portion of their surgery in advance as well.

4. **BILLING**

A. Statements are sent out monthly.

B. A statement will be sent to you even though your insurance company may be responsible for the payment. This allows you to keep track of how well your insurance company is serving you. Your statement will reflect the date on which your charges are filed to your insurance company. This will give you some idea as to how long it takes your insurance company to process your claim.

5. **TREATMENT POLICIES**

A. Most orthopedic problems can be treated by non-surgical means and every such means available that is indicated in the treatment of your particular illness will be exercised before surgical treatment is recommended.

B. Satisfactory results are not guaranteed for any type of surgical procedure as there is not a single operation that is 100% successful. Results of surgery are affected by genetics, life style and patient cooperation as well as surgeon skill. Medicine is also not an exact science. If surgery is recommended to you, the probability of a successful outcome will be explained to you. If you do not understand the reasons for the surgical procedure, its chances of success, or its possible complications, please ask us. Also, do not hesitate to ask us the charge for a particular operation if you desire that information.

C. An adult must accompany all patients under 18 years of age.

6. **MEDICATIONS**

Narcotic medications are prescribed only for patients in severe pain. Narcotic medications are not kept in the office. Requests for prescription refills should be made before 3:00p.m. Requests received after 3:00p.m. will be addressed the next business day. We do not prescribe prescriptions after business hours, on weekends or holidays.

7. **MEDICAL RECORDS**

A. Medical records will be sent to your insurance companies, attorneys, other physicians, etc. upon request of that person in writing.

B. The patient must sign a statement authorizing the release of information before this information can be sent to anyone.

8. **X-RAYS**

As a way to bettter serve you, Orthopaedic Associates uses digital x-ray. We are able to make a disc of the x-rays that are taken at our office. If you would like a copy of these x-rays there will be a $15 charge.

9. **DME**

In an effort to serve you faster and more thoroughly we have an on site durable medical equipment department. For those patients that are in need of a brace and have a qualifying insurance policy we carry the most commonly used orthopedic braces. To insure that you are getting a quality brace we have a no return policy on all of our DME.

FINANCIAL PAYMENT POLICY

In our effort to provide quality health care to our community, it is important to establish a clear credit policy to avoid any misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. All accounts are payable at the time of service. We accept VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS for your convenience. Payment arrangements are available through our trained Insurance Specialists in accordance with our Credit Guidelines. If you feel that you will not be able to pay your bill, please inform one of our receptionists so that a representative in the billing department can make payment arrangements.

As a service to our patients, we will bill your primary and secondary insurance carriers provided you supply the name, address, group and ID# and the name of the policyholder. If you prefer to bill your own insurance, we will furnish you with a complete itemized statement. We do not negotiate disputed claims with your insurance company. If you have questions regarding your coverage or any special arrangements, please contact your insurance carrier directly.

All patients will be required to sign an insurance release form that allows us to file their insurance to their carriers. Patients will also be required to sign a statement stating that they have read our Financial Payment Policy and will be responsible for their bill.

A. **Patient Responsibility. with Insurance**

1. Co-pays are due at the time of visit
2. Deductibles must be paid at the time of service, if not paid prior to your visit.
3. For surgery, arrangements for patient responsibility must be made in advance. Of course emergency surgery will be handled in manner applicable to the need.
4. All insurance payments will be monitored closely to assist you in experiencing the highest possible payout under your plan.
5. Portions not paid by your insurance carrier will become your responsibility.

B. **Patient Responsibility. without Insurance**

1. Payment is due upon receipt of the service. We accept all major credit cards for your convenience.
2. When considering payment arrangements, the following guidelines will be used:
   a. A Patient Responsibility Agreement form must be on file.
   b. The full balance must be arranged at the time of the first statement.
   c. All balances must be cleared within 12 months from the date of service.
   d. A Minimum monthly payment will be required.
   e. A Financial Agreement may be required when circumstances require arrangements beyond our standard guidelines.
   f. When surgery is scheduled, financial arrangements must be completed prior to the date of surgery.

C. **Managed Care**

Many insurance companies now have PPO and Participating Physician fee schedules. Contracts are negotiated on an annual basis. If you are part of one of these plans, please be sure to verify whether Orthopaedic Associates participates with your particular plan. We also try to verify this information and alert you prior to your visit if at all possible, however, it is ultimately the patient's responsibility. If your managed care plan requires a referral from your primary care physician (PCP), you are responsible for obtaining it prior to making your appointment. If you do not have a referral by the time of your visit, please refer to financial payment policy in regards to your responsibilty.

D. **Worker's Compensation Claims**

If your visit involves a worker's comp claim, notify the receptionist immediately. Authorization must be obtained prior to being seen. Please indicate if this is a new claim, open claim or if it has been some time since you spoke with your claims adjuster. Any charges not accepted as part of your claim become your responsibility.

E. **Motor Vehicle Accident Claims**

All motor vehicle accidents are billed to your auto insurance carrier. Once PIP is exhausted, the balance becomes your personal responsibility. We will bill your primary health insurance carrier, if applicable. Many times auto insurance will pay 80% of the charges. Patients will be responsible for the remaining 20%. Payment will be expected within our usual credit guidelines.

F. **Medicare**

As Medicare Participating Physicians, we accept the Medicare fee schedule. The patient is responsible for the annual deductible and 20% coinsurance at the time of service.

G. **Medicare and Supplement**

As Medicare Participating Physicians, we accept the Medicare fee schedule. After Medicare pays, your supplement will be filed. Only one Medicare supplement will be filed.

H. **Medicaid**

Orthopaedic Associates is not a participating provider for Medicaid. We are not able to bill Medicaid and any patient with Medicaid insurance is considered self pay. Payment is due at time of service.

I. **Disability Insurance**

Disability insurance forms will be completed for a small fee. Patients are asked to complete their portion of the form and leave it with the office. The forms will be mailed directly to the insurance company with copies available, on request. Please bring the forms in early to allow for adequate processing time.

Thank you for allowing us to serve you. If you need any assistance, please do not hesitate to ask. We are here to serve you.

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850-863-2153

Panama City
1827 Harrison Avenue
Panama City, FL 32405
(850) 785-4344

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

(Please read carefully)

This agreement is made between Orthopaedic Associates and Thomas Chad Mitchell, M.D., Michael Noble, M.D., Mark Awantang, M.D., John Ryan Cotton, M.D.,and Nicholas Crossman, D.O., and their physician extenders, agents, employees, or any of the forgoing referred to heinafter as "doctors" and (Patient name) _____ hereinafter referred to as "patient".

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any other persons deriving their claims through, and on behalf of, the patient. This agreement is intended to apply to loss of consortium claims, claims asserted by the patient's surviving spouse and any other derivative claims.

It is understood by the patient that he or she has voluntarily selected and he or she is neither required to use Orthopaedic Associates nor any of the doctors involved in their treatment and that there are other competent Orthopaedic physicians in Florida who may act as the patient's treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration.

Disputes and Consideration: In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences; (c) avoid lengthy drawn out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses and attorney's fees.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery available under the Florida Rules of Civil Procedure. In addition, the Florida Evidence Code as well as Chapter 766 and 768, Florida Statutes shall apply to this arbitration proceeding. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s).

If any provision of this agreement is declared to be unlawful, invalid or unenforceable for any reason, then notwithstanding such unlawfulness, invalidity or unenforceability, the remaining terms and provision of this agreement shall remain in full force and effect. Further, all terms and conditions of this Agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

Patient initials _____ I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date. **By signing below, I am also indicating that I am over the age of eighteen (18) and that I have read, understood and agree to the foregoing terms.**

In witness whereof, we have set our hands this date:

PATIENT:

By: _____
(Patient Signature)

By: _____
(Patient's Legal Guardian if under 18)

WITNESS:

By: _____
(Employee of Orthopaedic Associates)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on January 1, 2014 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include diagnosis, nature of services and treatment. If you have elected to opt out, we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $10.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: **Orthopaedic Associates**
Telephone: (850) 785-4344
Address: 1827 Harrison Ave, Panama City, FL 32405

Privacy Officer: DELFORD GREGGS
Fax: (850) 505-3066
Email: dgreggs@orthoassociates.net

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of Orthopaedic Associates Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Patient Printed Name

_____

Patient or Legal Guardian Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

❒ The patient refused to sign.

❒ Due to an emergency situation it was not possible to obtain an acknowledgement.

❒ We weren't able to communicate with the patient.

❒ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee Signature *Date*

_____ _____

Employee Printed Name *Title*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

ORTHOPAEDIC ASSOCIATES
The Strength of Experience

P: 850-785-4344 F: 850-505-3066
www.orthoassociates.net

Fort Walton
1031 Mar Walt Drive
Fort Walton Beach, FL 32547
850-863-2153

Destin
36474C Emerald Coast Parkway
Suite 3101 Destin, FL 32541
850-863-2153

Niceville
554-D Twin Cities Boulevard
Niceville, FL 32578
850-863-2153

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536
850-863-2153

Panama City
1827 Harrison Avenue
Panama City, FL 32405
(850) 785-4344

Dear Patient,

Thank you for choosing Orthopaedic Associates for your medical needs. We pledge to give you the best medical care possible and treat you with friendliness, respect, and dignity. We appreciate your business.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Sincerely,

Delford H. Greggs, Jr., CPA
CEO

Patient / Legal Guardian Signature: _____

Date: _____

FORM 119, Rev. 10/22