ORTHOPAEDIC & SPORTS SPECIALISTS, P.C.

WORKER COMPENSATION INFORMATION FORM

Referred By: _____ Todays Date: _____

Address: _____

Phone Number: _____

CHECK ONE: [ ] ATTORNEY [ ] HOSPITAL [ ] EMERGENCY ROOM [ ] EMPLOYER [ ] PHYSICIAN

[ ] OTHER: _____

PATIENTS NAME: _____ DATE OF BIRTH: _____

AGE: _____ CIRCLE ONE: GENDER: M F MARITAL STATUS: S M D W

SOCIAL SECURITY NUMBER: _____
DRIVER'S LICENSE NUMBER: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYERS ADDRESS: _____

SUPERVISOR: _____ EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NUMBER: _____

PREVIOUS DOCTOR OR DOCTORS WHO HAVE TREATED YOU FOR THIS INJURY:

_____ _____

_____ _____

FOR OFFICE USE ONLY

CLAIM NUMBER: _____ COURT #: _____

DOI: _____ BODY PART TO BE EXAMINED: _____

ADJUSTOR: _____ P#: _____ F#: _____

NCM MANAGER: _____ P#: _____ F#: _____

[ ] APPROVED [ ] DENIED [ ] EVAL AND TREAT [ ] EVAL ONLY

WORK COMP CARRIER: _____

ADDRESS: _____

UPDATED: 05-20-2015

ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C.

Date and time of accident/injury _____

State in your own words how the accident/injury happened _____

_____

_____

Where you seen by a Hospital? [ ] Yes [ ] No Admitted? [ ] Yes [ ] No Emergency Room only? [ ] Yes [ ] No

Name of Hospital_____Date Seen_____

Were you seen at another Physician? [ ] Yes [ ] No Name_____

How long have you been off work since the accident/injury? _____

If you had more than one job/employer at the time of the accident/injury- state every employer with name and address

_____

_____

_____

WORK HISTORY:

At the job where the accident/injury occurred describe your job responsibilities _____

_____

If you have another job/employer- describe your job responsibilities there _____

_____

Have you ever been injured on the job before? [ ] Yes [ ] No If YES, state when and what type of injury

_____

LEGAL INFORMATION:

IF YOU ARE REPRESENTED BY AN ATTORNEY

Attorney's name: _____

Address: _____

City, State, Zip Code:_____

_____

Telephone: _____

Release of Information:

I hereby authorize release of information to the WORKERS COMPENSATION INSURNACE COMPANY and to ATTORNEY OF RECORD (If attorney has been retained). I I hereby state that all the information given by myself in reference to this accident/injury is correct to the best of my knowledge. My signature indicates I have read and do grant release.

_____ _____

Date Patient Signature

BENEFITS TO PHYSICIAN:

APPROVED OR COURT ORDERED

WORKERS COMPENSATION CLAIMS

I hereby authorize all payments direct to physician for medical and or surgical benefits.

_____ _____

Date Patient Signature

PENDING OR UNVERIFIED

WORKERS COMPENSATION CLAIMS

I hereby authorize all payments directly to physician for medical and/or surgical benefits. I also understand that I am responsible for any portion of my medical charges not authorized by workers compensation.

_____ _____

Date Patient Signature

Orthopaedic and Sports Specialists
Cancellation/ No Show Policy

Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance there will be a twenty-five dollar ($25) fee; this will not be covered by your medical insurance company or workers compensation coverage. You will be responsible for this charge.

Sign: _____ **Date:**_____

Policy Regarding Late Appointments

Scheduled Appointments

We understand that delays can happen however, we must try to keep other scheduled patients and the doctor on time.

Patients who arrive 20 minutes after their scheduled time, may have to reschedule their appointment.

Sign:_____ **Date:**_____

ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C.

NOTICE OF INSURANCE AND FINANCIAL POLICY

I understand that I am responsible for the payment of this account and hereby assume and guarantee prompt payment of all expenses incurred. I understand that my health insurance is a contract between me, my employer and the insurance company. I understand Orthopaedic & Sports Specialists, P.C. herein referred to as OSS is not responsible to guarantee coverage, payment, authorization, or provider participation status with my insurance carrier. I understand and agree that I am responsible for payment of my health insurance co-pays and deductibles and per my insurance contract is due at the time of my visit. I understand that if a co-pay or payment is due at the time of my appointment and I refuse to pay that my appointment may be rescheduled to another day. I hereby request and authorize OSS to bill my insurance policies written in the United States and insurance companies based in the United States for all charges of services provided to me and I authorize payment to Orthopaedic & Sports Specialists, P.C. for all such services. I understand that durable medical supplies required for treatment of my orthopaedic condition, and which have a charge of $20.00 or less will be charged to my account and filed with my insurance, without separate verbal and/or written notice at the time of placement and if not reimbursed by my insurance company then I will be held financially responsible for the charge. I understand and agree that I may be required to provide a down payment prior to surgical procedures based on my estimated financial responsibility. I understand that Oklahoma law requires my insurance company to pay the claim within (30) thirty days of receiving a clean HCFA 1500 claim form or to notify all parties involved as to why the claim processing is being delayed. If my insurance company does not process and/or render payment within sixty (60) days from the date of service and the reason is due to information that my insurance company is requesting from me and I have not responded then I acknowledge that I will be the one held responsible for the account balance. I understand OSS may require me to show proof that I responded to my insurance company inquiry. If a balance is not paid after being notified by mail or telephone that patient's account is delinquent and the account is turned to the collection agency then it is OSS policy that all patients under that account number will not be eligible for reappointment. In addition, it is my obligation to notify OSS of any changes in my contact numbers, i.e. mailing address or telephone number(s) for accurate communications. I further understand that Dr. Mark Kowalski is invested in Oklahoma Center for Orthopaedic and Multispecialty and Surgery Center of Oklahoma. ******I understand that if I do not give my current insurance information on the date of my appointment that I will be held financially responsible for all charges and fees associated with the treatment rendered. If OSS receives from you your corrected insurance information then the claim(s) will be refiled for you. Although we will provide refiling as a courtesy to you if the medical claim(s) are after your insurance timely filing period then you will be held responsible for the medical charges even if your insurance explanation of benefits (EOB) states patient not responsible due to not filing in a timely manner since the error was your fault not OSS. This policy applies even if OSS participates in the new insurance which was not presented at the time of service.***

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES

I UNDERSTAND THAT MY INSURANCE CARRIER OR MEDICARE may deny payment or consider some or all of the services performed by Orthopedic & Sports Specialists, such as assistant surgeon fees, durable medical equipment and/or supplies, to be "non-covered," and that I am fully responsible for payment of all such non-covered services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE (UCR)" CLAUSES

For patients with Usual, Customary and Reasonable coverage I acknowledge that the fees charged by Orthopedic & Sports Specialists for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable" due to specialized services and staff. However, I agree to pay all fees in full, even if the amount is greater than the amount paid by my insurance company.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize Orthopedic & Sports Specialists, P.C. (OSS) to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, workers compensation insurance company, other third-party payers as reasonably necessary to expedite claim processing. This authorization is valid for every visit to Orthopedic & Sports Specialists, P.C. (OSS) or affiliates until written notice revoking this financial policy is provided. I release Orthopedic & Sports Specialists, P.C. (OSS) of all responsibility or liability for loss of confidentially through access and/or copies of records released, or other information disclosed incompliance with this authorization. When date of service information is released then all the medical information obtained for that date of service (office note) is released which may include the patient's entire past medical history information.

I confirm that I have read all of the above information. I attest that I was given the opportunity to ask any questions regarding the above information. By signing below I am stating that I understand and agree to all provisions addressed above regarding my responsibilities, the responsibility for payments and the release of information.

Patient's Name: (Print): _____

Patient or Legal Guardian's Signature: _____ Date: _____

If Legal Guardian Relationship to Patient: _____

HEALTH HISTORY

Name _____ Today's Date _____

Age _____ Date of Birth _____ **Primary Care Physician & Phone number** _____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Sweats

HEAD, EARS, EYES

- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision flashes/halos
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Earache
- ☐ Ear discharge
- ☐ Loss of Hearing
- ☐ Ringing in ears

Nose, Sinus, Throat

- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sleep Apnea

HEMATOLOGICAL

- ☐ Anemia
- ☐ Bleeding disorder_____

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema

NEUROLOGICAL

- ☐ Depression
- ☐ Epilepsy
- ☐ Migraine Headache
- ☐ Multiple Sclerosis

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Heart disease
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

VASCULAR

- ☐ Aneurysm
- ☐ Blood Clot / DVT
- ☐ Phlebitis
- ☐ Stroke

ENDOCRINE

- ☐ Diabetes _____
- ☐ Goiter
- ☐ Thyroid problems
- ☐ Other _____

IMMUNE SYSTEM

- ☐ AIDS
- ☐ Blood transfusion
- ☐ HIV positive
- ☐ Immuno suppression
- ☐ Organ transplant recipient
- ☐ Other _____

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Prostate Cancer
- ☐ Prostate Problems
- ☐ Sore on penis
- ☐ Other _____

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Vaginal infection
- ☐ Other _____

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

BREAST

- ☐ Cancer
- ☐ Benign growth
- ☐ Nipple discharge
- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Other _____

CONDITIONS Check (√) conditions you have or have had in the past.

- ☐ Alcoholism/Abuse
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Bulimia
- ☐ Cancer _____
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Gonorrhea
- ☐ Gout
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Osteoporosis/Osteopenia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Suicide Attempt
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other _____
- ☐ Other _____

MEDICATIONS List medications you are currently taking, prescription and over the counter

ALLERGIES medication/other

Pharmacy Name _____ Phone _____

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (√) if, your blood relatives had any of the following: (√)	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any	

HEALTH HABITS Check (√) all which apply and fill in amounts

Substance	√	Current Users ,quantity cups, glasses, cans, cigs a day	Former Users, quantity used and when stopped
Coffee			
Soda			
Tea			
Alcohol			
Drug			
Cigarettes/ Cigars			
Smokeless Tobacco			
Vapor or E-Cig			

General Surgeries

Year	Hospital	Procedure	Complications

Cardiac Surgeries

Cardiologist _____ **Phone** _____ **Date last seen** _____

Year	Hospital/ Surgeon	Procedure	Complications

Orthopaedic Surgeries

Year	Hospital/ Surgeon	Procedure	Complications

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No,** If yes please give approximate dates. _____

Occupational Concerns Check (√) if your work exposes you to the following:

☐ Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other_____ Occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations** and DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS OF ORTHOPAEDIC AND SPORTS SPECIALISTS,P.C.

I understand that as part of my health and medical care, ORTHOPAEDIC & SPORTS SPECIALISTS, P.C. originates and maintains electronic medical and health records, describing, but not limited to my health history, symptoms, physician examination, medications, x-ray and/ or radiology test results (such as MRI, CT scan, EMG/NCT, or Arthrogram) , EKG reports, operative reports, diagnoses, current treatment, disability status, functional capacity evaluations, durable medical goods ordered, plans for future care or treatment, as well as a permanent disability rating if so required. I further understand that this information serves as:

+ a basis for planning my care and treatment

+ a means of communication among the health professionals who contribute to my care

+ a source of information for applying my diagnosis and treatment information to my bill

+ a means for a third-party payer to verify that services were billed as actually provided

+ and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I can have secure access to my health records electronically by viewing my health record at viewmyhealthrecords.com. The pamphlet explaining how to access my electronic health records can be obtained from the office staff of ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. If I do not wish to view my records electronically, I am aware that I may request , in writing, that ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. reproduce a copy of my health record. The office staff will supply a form to be completed to ensure that I receive the medical records which I require.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that ORTHOPAEDIC & SPORTS SPECIALISTS, P.C. reserves the right to change their notice and practices. Prior to implementation, as a current treating patient, I will receive and be required to sign a copy of any revised notice . I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that ORTHOPAEDIC & SPORTS SPECIALISTS. P.C. is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

Name of Patient_____ Date of Birth_____

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

_____ _____

_____ _____

I request the following restrictions to the use and/or disclosure of my health information:_____

_____

You ____ may _____ may not leave (appointment reminders) (medical information) on my message service or machine.

You ____ may _____ may not fax information to me. My fax number is: _____

You ____ may _____ may not contact me by E-mail. My E-mail address is: _____@_____

_____ _____

Signature of Patient or Legal Representative Date Notice Effective

ORTHOPAEDIC & SPORTS SPECIALISTS, P.C._____ accepts _____ denies _____ accepts conditionally the restrictions imposed on release of information as stated above.

_____ _____

Orthopaedic Employee Signature and Title Date

As a prospective patient of Oklahoma Center of Orthopaedic and Multi-Specialty Surgery and OCOM Imaging it is our responsible to inform you of the following:

1. Mark F. Kowalski, M.D. has an ownership interest in Oklahoma Center of Orthopaedic and Multi-Specialty Surgery and OCOM Imaging.
2. In addition, other physicians that may treat you at the hospital or imaging center(s) may have an ownership in the facilities.
3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Oklahoma Center of Orthopaedic and Multi-Specialty Surgery and OCOM Imaging. You will not be treated differently by Dr. Mark Kowalski or his staff if you choose to use a different facility. If desired, our office can provide information about alternative providers that are available. We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask our office manager.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and understand that your physician, Mark F. Kowalski, M.D. has an ownership interest in the above named entities.

_____

Signature of patient or Signature of patient's legal guardian or representative Date

HIPAA PATIENT PRIVACY NOTICE

For

ORTHOPAEDIC & SPORTS SPECIALISTS, P.C.

Effective Date: 03/26/2013 updated 5/12/2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the office manager or the receptionist.

WHO WILL FOLLOW THIS NOTICE:

This notice describes our office's practices and that of:

Any health care professional or entity authorized to enter information into your file or record.

All employees, staff and other personnel.

Private contractors and Business Associates of Covered Entities as listed: Professional Answering Service, Integrated Solutions Group Technology, Medical Office Solutions, MD Logic, Inservio/MedAssist, Account Management Resources, Earl Olgetree, Attorney-At-Law and Associates as legal counsel for PLICO risk management department. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or hospital operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to protected medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PERMITTED MEDICAL INFORMATION.

As well as the listed entities previously listed above as Business Associates, the following categories describe different ways that we use and disclose protected medical information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use protected medical information about you to provide you with medical treatment or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists, home health agencies, physical therapists, durable medical goods suppliers, nursing or assisted living facilities, radiological facilities, hospitals, and ambulatory surgical centers as well as their personnel who are involved in giving you medical care

or ordering medical devices, drugs, or supplies for you. Different departments of our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected medical information about you to people outside the practice who may be involved in your medical care, such as family members or others we use to provide services that are part of your care. We make every attempt to have your permission prior to any of these disclosures, but in an emergency situation we reserve the right to use and disclosure pertinent and necessary medical information as required for your benefit.

For Payment: We may use and disclose protected medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party payor. For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We also may use and disclose your information to obtain payment from third party payers that may be responsible for such costs, such as family members. And we may use your information to bill you directly for services and items.

Appointment Reminders: We may use and disclose protected medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release protected medical information about you to a friend or family member who is involved in your medical care or release limited medical information to someone who helps pay for your care. We may also tell your family or friends your current medical condition in certain situations as deemed medically necessary. In addition, we may disclose protected medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: Under certain circumstances, we may use and disclose protected medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care in our practice.

As Required By Law: We may use or disclose your protected medical information about you when required to do so by federal, state or local law and such use disclosure is limited to the relevant requirements of such law.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Healthcare operations: We may use protected health information provided to us by your covered entity to assist your covered entity in serving you better. For example, we may provide conference capabilities for your physician to consult with other medical staff, we may provide customer service on behalf of your insurance carrier to assist you with your insurance benefits, or we may provide recall notifications for a recalled medical device you may use or have used during a surgical procedure.

Honoring patients' request to restrict information:

1. Our office will make a notation in the electronic medical record to ensure that the information doesn't independently get sent to your health insurance or disability plan. See also #7 of this category for further explanation.
2. If a treatment is part of a bundled service, we can counsel you, as the patient or authorized guardian on the ability to unbundle the service and the impact of the payment to the provider of service. If the requested restriction cannot be unbundled you will so be informed and given the option of paying for the entire medical bundled service out of pocket in full.
3. If you do not wish your downstream providers, such as pharmacists, other specialists, treatment facilities, etc. to have the same restrictions regarding medical information to be released or not to be released you are encouraged to alert these downstream providers and our office is willing to assist you with this process by sending a written form instructing them of your wishes to restrict information.
4. If you are an HMO patient and cannot pay out-of-pocket for items, other than cost sharing, you will be advised that you will be using an out of network provider.
5. If you as the patient request to pay directly to avoid an insurance claim, we have the right to make a reasonable effort to get the payment from you prior to billing the insurance plan.
6. If you receive subsequent related treatment and do not request a subsequent restriction, our office can include the previously restriction information in accordance with the minimum necessary rules of the plan and our office will make an attempt to advise you before doing so.
7. You may request a restriction of your protected health information or disclosure about you for payment or health care operations. You also have the right to request limiting disclosures of your protected health information to family members or friends who are involved in your care or payment of your care, The insurance healthcare plan you are enrolled in does not always agree to such restrictions that you have requested we honor as it is a personal policy between you as the insured and the insurance company.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release protected medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces or a veteran of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority, if you are in their service.

Workers' Compensation: We may release protected medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Release of such information is controlled by state and/or federal law.

Public Health Risks: We may disclose protected medical information about you, when required or permitted by law, to disclose your protected health information to public or legal authorities responsible for preventing or controlling disease, injury, or disability or performing other public health functions. These activities or disclosures generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report a known or suspected crime,
- To report child abuse or neglect;
- To report vulnerable adult abuse;
- To report reactions to medications or problems with products;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release protected medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct involving our practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Medical Examiners and Funeral Directors: We may release protected medical information to a medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release protected medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release protected medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose protected information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for this practice to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Judicial and Administrative Proceedings: We may disclose your protected health information for judicial or administrative proceedings as required or permitted by law or in response to a valid subpoena, court order, or other binding authority.

Food and Drug Administration (FDA): We may disclose to the FDA, or entity subject to FDA jurisdiction, your protected health information for public health purposes related to the quality, safety or effectiveness of an FDA related product or activity for which that person has responsibility. For example, your information may be disclosed in connection with the reporting of an adverse event, product defect, product tracking, or to provide post marketing surveillance information as so required.

Secretary of the U.S. Department of Health and Human Services: We may disclose as they require us by law, to release your protected health information to this federal agency directly or to the Office of Civil Rights. Note that under federal law, you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all circumstances, you may have a right to have this decision reviewed.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding protected medical information we maintain about you:

Right to understand how your health information may be used and disclosed: You have the right to ask questions about the health privacy issue(s) and have those questions clearly and promptly answered,

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not necessarily include psychotherapy notes. Your request must be in writing and disclosed on a form supplied from our company, Orthopaedic and Sports Specialists, P.C. which specifically states what information and to whom you are wanting the information released to.

To inspect and/or copy your medical information you must submit your request to the medical records clerk in our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. (By statute in Oklahoma we may charge you $0.25 per page for copies, plus our postage costs. If your record contains any item that requires a photographic process to copy, such as an x-ray or photograph, we may charge you up to $5.00 per image.)

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our practice.

To request an amendment, your request must be made in writing and submitted to the medical records clerk. In addition, you must provide a reason that supports your amendment request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- In our judgment is accurate and complete as it appears or as it was at the time it was originally captured and recorded.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of your medical information.

To request this list or accounting of disclosures, you must submit you request in writing to the medical records clerk in our office. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically sent if electronic submission is available from our office). The first list you request within each 12 month period will be free. For additional lists, we may charge you for the costs of providing the list at a reasonable rate. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected medical information we use or disclose about you for treatment, payment or health care operations. However, we must receive your restrictions in writing before we have made such disclosures. Also, if you restrict our right to use your protected medical information for treatment, payment or health operations, we reserve the right to immediately withdraw our services form you and terminate the physician-patient relationship.

You also have the right to request a limit on the protected medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery to your family.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the medical records clerk in our office. In your request restrictions, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or at home, or by mail, or by phone, or by E-mail.

To request confidential communications, you must make your request in writing to the medical records clerk in our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Copy of This Notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, the effective date. In addition, each time you are in our office for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office manager or the HIPPA Privacy Officer for Orthopaedic & Sports Specialists, P.C. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of protected medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

- end -

ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C.

4140 W. MEMORIAL SUITE 308
OKLAHOMA CITY, OKLAHOMA 73120
TELEPHONE (405)749-7031 FAX (405)749-7036

Original HIPAA Patient Privacy Notice dated 04/04/2003, updated 05/12/2014

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of HIPAA Privacy Notice and Practices, which states how we may use and or disclose your health information. Please sign this form to acknowledge receipt of this notice.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. HIPAA PRIVACY NOTICE AND PRACTICES.

Print your name as patient or patient's guardian Date

Signature

EMPLOYEE SECTION ONLY:

We have made every effort to obtain written acknowledgment of receipt of our notice of privacy notice and practices from this patient but it could not be obtained because:

O The patient refused to sign O We were unable to communicate with the patient
O Due to an emergency situation it was not possible to obtain an acknowledgement.
O Other_____

Employee Signature and Date: