

ORTHOPAEDIC MEDICINE AND SURGERY
1015 18th Street NW, Suite 300 • Washington, DC 20036 • (202) 835-2222
PATIENT INFORMATION SHEET

Appointment Date: ___/___/___

Time: ___:___ AM / PM

Today's Date: _____

PLEASE PRINT

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Sex: Male or Female
Number and Street City State Zip Code

Employer: _____ Occupation: _____

Employer's Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____ Email: _____
Area Code Area Code Area Code

Date of Birth: _____ Age: _____ SSN# _____ Marital Status: Single • Married • Separated • Widowed • Divorced

Spouse's Name: _____ Telephone Number: _____ (Home • Work • Cell)

Emergency Contact: _____ Relation to Patient: _____ Telephone Number: _____

Pharmacy: _____ Telephone Number: _____

Name of Referring MD (if applicable): _____ Telephone Number: _____

Primary Care Physician: _____ Telephone Number: _____

Name of Physician you are seeing today (Please Circle)

Louis E. Levitt, MD • Marc B. Danziger, MD • Mark J. Scheer, MD • Noah M. Raizman, MD
Benjamin E. Stein, MD • Hassan Alish, MD • Kelly A. Donahue, PA-C

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Group# _____ ID/Policy# _____

Insurance Company Address: _____ Telephone number: _____

Subscriber's Last Name: _____ First Name: _____ MI: _____ Sex: Male or Female

Subscriber SS# _____ Date of Birth: _____ Relation to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ Group# _____ ID/Policy# _____

Insurance Company Address: _____ Telephone number: _____

Subscriber's Last Name: _____ First Name: _____ MI: _____ Sex: Male or Female

Subscriber SS# _____ Date of Birth: _____ Relation to Patient: _____

Legal Name: _____ Marital Status: Single • Married • Separated • Widowed • Divorced

Employer's Name: _____ Occupation: _____ Work Number: (____) _____

Employer's Address: _____

Date of injury/onset of condition: _____

How and where did the injury occur: _____

Is this visit the result of an accident: NO YES If YES, please indicate: Worker's Comp : Auto: Other:

We do not recognize third party liability. You will be responsible for payment of all charges at the time of treatment.

WORK RELATED INJURY

(Only complete this section if your injury is work related)

Date of injury/onset of symptoms: _____

Compensation Insurance Carrier Name: _____

Insurance Company Address: _____ Phone: (____) _____
Area Code

Employer: _____ Employer's Phone: (____) _____
Area Code

Employer's Address: _____

Was the injury reported to the Supervisor/Employer? Yes No Supervisor's Name: _____

ATTORNEY REPRESENTATION

(Only Complete if an attorney is representing you for your injury)

Attorney's Name: _____ Phone: (____) _____
Area Code

Attorney's Address: _____

PLEASE READ AND SIGN

I, the undersigned, hereby authorize Louis E. Levitt, MD, Marc B. Danziger, MD, Mark J. Scheer, MD, Noah M. Raizman, MD, Benjamin E. Stein, MD, Hassan Alosch, MD and/or Kelly A. Donahue, PA-C to apply for benefits on my behalf for covered services rendered to me by one of the above.

I authorize payment directly to the Practice for services for which the Practice accepts assignment.

I, the undersigned, realize that I am financially responsible for all services rendered to me by Orthopaedic Medicine and Surgery.

I understand that payment for services is not contingent on recovery and that this does not relieve me of my personal, primary obligation to pay for services rendered and any costs incurred in the collection of these charges, including reasonable attorneys fees.

For those insurances for which the Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services as dictated by my insurance coverage.

I authorize the Practice to release to my insurance carrier(s)/employer/attorney any medical information necessary to obtain reimbursement.

I certify that the above information is correct. I permit a copy of this authorization to be use in place of the original.

**** IF UNABLE TO KEEP AN APPOINTMENT KINDLY GIVE 24 HRS NOTICE. OTHERWISE ****
WE RESERVE THE RIGHT TO CHARGE \$25.00 FOR TIME RESERVED.

Signature of Patient or Parent/Legal Guardian

Date

Medical disorders: If you have had any of the following, Place Mark inside Circles

- | | | |
|--|---|---|
| <input type="radio"/> No Medical History | <input type="radio"/> Stroke | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Cancer Breast | <input type="radio"/> Gout |
| <input type="radio"/> Alcoholism | <input type="radio"/> Cancer Colon | <input type="radio"/> Heart Attack |
| <input type="radio"/> Alzheimer's | <input type="radio"/> Cancer Lung | <input type="radio"/> High Blood Pressure |
| <input type="radio"/> Anemia | <input type="radio"/> Cancer Prostate | <input type="radio"/> Hepatitis |
| <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> COPD | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Asthma | <input type="radio"/> Depression | <input type="radio"/> Osteoarthritis |
| <input type="radio"/> Blood Clot Leg | <input type="radio"/> Diabetes | <input type="radio"/> Seizures |
| <input type="radio"/> Blood Clot Lung | <input type="radio"/> Drug Abuse | <input type="radio"/> Ulcers, Bleeding |
| <input type="radio"/> Other Disease (list below) | <input type="radio"/> Blood thinners (Coumadin, Plavix, aspirin, etc) | |

Surgical History: If you have had any of the following, Place Mark inside Circles

- | | |
|---|--|
| <input type="radio"/> No Surgical History Reported | <input type="radio"/> Cardiac (Heart) |
| <input type="radio"/> Carpal Tunnel Left Wrist | <input type="radio"/> Carpal Tunnel Right Wrist |
| <input type="radio"/> Arthroscopy Left Elbow | <input type="radio"/> Arthroscopy Right Elbow |
| <input type="radio"/> Arthroscopy Left Shoulder | <input type="radio"/> Arthroscopy Right Shoulder |
| <input type="radio"/> Arthroscopy Left Ankle | <input type="radio"/> Arthroscopy Right Ankle |
| <input type="radio"/> Arthroscopy Left Knee | <input type="radio"/> Arthroscopy Right Knee |
| <input type="radio"/> Arthroscopy Left Hip | <input type="radio"/> Arthroscopy Right Hip |
| <input type="radio"/> Left Hip Replacement | <input type="radio"/> Right Hip Replacement |
| <input type="radio"/> Left Knee Replacement | <input type="radio"/> Right Knee Replacement |
| <input type="radio"/> Spinal Fusion | <input type="radio"/> Laminectomy |
| <input type="radio"/> Other Surgery (list in the box below) | <input type="radio"/> Fracture Surgery |

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| | | <input type="radio"/> Osteoarthritis |

Mother Medical History

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| | | <input type="radio"/> Osteoarthritis |

Sibling Medical History

- | | | |
|---|------------------------------------|--|
| <input type="radio"/> AIDS/HIV | <input type="radio"/> Diabetes | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Liver Disease |
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Attack | <input type="radio"/> Muscle Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Hypertension | <input type="radio"/> Rheumatoid Arthritis |
| | | <input type="radio"/> Osteoarthritis |

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional

- Weight Loss/Gain
- Weakness
- Fatigue
- Fever

Eyes

- Glasses or Contacts
- Blurred Vision
- Glaucoma
- Cataracts
- Excessive Tearing

Ear Nose Mouth Throat:

- Ears Ringing
- Earaches
- Hearing Aid
- Frequent Colds
- Nasal Discharge
- Hay Fever
- Nosebleeds
- Dentures
- Bleeding Gums
- Frequent Sore throats

Endocrine

- Thyroid Trouble
- Excessive Sweating
- Excessive thirst

Cardiovascular

- High Blood Pressure
- Chest Pain
- Rheumatic Fever
- Palpitations
- Has Pacemaker

Skin

- Rashes
- Sores
- Lumps
- Dryness
- Itching

Neurological

- Headache
- Dizziness
- Seizures
- Loss of Sensation
- Vertigo

Gastrointestinal

- Heart Burn
- Rectal Bleeding
- Abdominal Pain
- Gallbladder trouble
- Hepatitis

Immunologic

- Reactions to Drugs
- Skin Rashes
- Reactions to Foods

Musculoskeletal

- Joint Pain
- Arthritis
- Muscular Weakness
- Stiffness
- Muscular Pain

Blood or Lymph

- Anemia
- Easy Bruising
- Easy Bleeding
- Swollen Glands

Respiratory

- Shortness of Breath
- Cough
- Wheezing
- Asthma
- Bronchitis

Genitourinary

- Blood in Urine
- Urinary Infections
- Kidney Stones
- Burning Urination
- Sexual Disease

Psychological

- Nervousness
- Depression
- Mood Changes

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco? Yes No Former

Use Alcohol? Yes No

Use Caffeine? Yes No

Use Illicit Drugs? Yes No

I do not use any of the above

Hand Dominance? Right Handed Left Handed

Females Only:

Could you be pregnant? Yes No

Allergies: Do you have allergies to any of the following medications or substances

- | | | |
|--|--------------------------------|---------------------------------|
| <input type="radio"/> No Known Allergies | <input type="radio"/> Aspirin | |
| <input type="radio"/> Penicillin | <input type="radio"/> Amoxil | <input type="radio"/> Tegretol |
| <input type="radio"/> Codeines | <input type="radio"/> Keflex | <input type="radio"/> Bactrim |
| <input type="radio"/> Sulpha Drugs | <input type="radio"/> Cefzil | <input type="radio"/> Pediazole |
| <input type="radio"/> Iodine / Shellfish | <input type="radio"/> Ceftin | <input type="radio"/> Dilantin |
| <input type="radio"/> Ampicillin | <input type="radio"/> Suprax | <input type="radio"/> Novacaine |
| <input type="radio"/> Vantin | <input type="radio"/> Septra | <input type="radio"/> Insulin |
| <input type="radio"/> Depakene | <input type="radio"/> Lamictal | <input type="radio"/> Lidocaine |

Other Allergies:

- Latex IVP/X-Ray Dye Metal Egg/Avian (Bird)

List any other allergies in this box

ORTHOPAEDIC MEDICINE AND SURGERY

(PLEASE PRINT)

Today's Date: _____

Patient's Name: _____ Height: _____ Weight: _____

Reason for visit today: (Please describe in detail your injury or problem)

CURRENT MEDICATIONS

Name	Dose	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH HABITS/DIETARY SUPPLEMENTS

Vitamins Yes No _____
Calcium Yes No _____
Estrogen Yes No _____
Tobacco Yes No If yes, what type/how often? _____
Have you ever used/smoked? Yes No If yes, date you quit: _____
Alcohol Yes No If yes, amount/how often? _____
Coffee/Tea Yes No _____ Cups a day
Exercise Yes No If yes, amount/type? _____

HOSPITALIZATIONS/OPERATIONS

Reason	Date
_____	_____
_____	_____
_____	_____

What other information should your doctor be aware of?

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Sign: _____ Date: _____

PHYSICIAN USE ONLY: Reviewed by _____ Date: _____

Orthopaedic Medicine & Surgery

Louis E. Levitt, MD • Marc B. Danziger, MD

Mark J. Scheer, MD • Noah M. Raizman, MD • Benjamin E. Stein, MD

PRACTICE LIMITED TO ORTHOPAEDIC SURGERY & MEDICINE

1850 M Street NW • Suite 750 • Washington, DC 20036 • 202-835-2222

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 ___ O.K. to leave message with detailed information
 ___ Leave message with call-back number only

- Written Communication
 ___ O.K. to mail to my home address
 ___ O.K. to mail to my work/office address
 ___ O.K. to fax to this number _____

- Work Telephone _____
 ___ O.K. to leave message with detailed information
 ___ Leave message with call-back number only

- Other (please specify)

 Patient Signature

 Date

 Print Name

 Date of Birth

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosure of Protected Health Information

Today's Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operation

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; O=Other

**ORTHOPAEDIC MEDICINE AND SURGERY
PATIENT FINANCIAL TERMS AND CONDITIONS**

Orthopaedic Medicine and Surgery is committed to providing you with the best possible care and service. Unless we are a participating provider with your insurance plan, it is ultimately your responsibility to pay the practice for services rendered, and to assure that your insurance properly processes your claim and pays the provider. If Orthopaedic Medicine and Surgery participates with your insurance, it is your obligation to remit all relevant insurance policy information, and pay all coinsurance and copays.

The office will gladly discuss your proposed treatment and charges, and will answer any questions relating to your insurance. You must realize that Orthopaedic Medicine and Surgery will expect payment on all services from an out of network insurance plan, since we are not bound by contract or fee schedule. This is to include any services or appliances not covered by insurance.

Returned checks will be subject to a \$36 fee. In the unfortunate event collection procedures are required, the patient shall be responsible for the reasonable cost (35% of the past due balance) of a collection agency, attorney, and/ or court costs.

Patient

Date

Orthopaedic Medicine & Surgery

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PATIENT AGREEMENT FOR PAYMENT OF NON-COVERED SERVICES

I, the undersigned, understand that certain services may not be a benefit covered by my health plan. I agree to be financially responsible for payment for this service provided to me or my dependent by the office of Orthopaedic Medicine and Surgery

Patient Name-Print

Date

Patient/Guardian Signature

Insurance Plan

OFFICE OF ORTHOPAEDIC MEDICINE & SURGERY

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Orthopaedic
Medicine & Surgery's Notice of Privacy Practices.

Signature of Patient

Date

NOTICE OF PRIVACY PRACTICES

This Notice is effective March 26, 2013

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

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request. Please contact our Privacy Officer at **202-835-2222** to obtain a copy of our current Notice).

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at **202-835-2222**.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at **202-835-2222**.

1. Treatment

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

Example: Jane is a patient at the health department. The receptionist may use medical information about Jane when setting up an appointment. The nurse practitioner will likely use medical information about Jane when reviewing Jane's condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the nurse practitioner concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.

2. Payment

We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within the health department, we may use medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

Example: Jane is a patient at the health department and she has private insurance. During an appointment with a nurse practitioner, the nurse practitioner ordered a blood test. The health department billing clerk will use medical information about Jane when he prepares a bill for the services provided at the appointment and the blood test. Medical information about Jane will be disclosed to her insurance company when the billing clerk sends in the bill.

Example: The nurse practitioner referred Jane to a specialist. The specialist recommended several complicated and expensive tests. The specialist's billing clerk may contact Jane's insurance company before the specialist runs the tests to determine whether the plan will pay for the test.

3. Healthcare Operations

We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.

- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

Example: Jane was diagnosed with diabetes. The health department used Jane's medical information – as well as medical information from all of the other health department patients diagnosed with diabetes – to develop an educational program to help patients recognize the early symptoms of diabetes. (**Note:** The educational program would not identify any specific patients without their permission).

Example: Jane complained that she did not receive appropriate healthcare. The health department reviewed Jane's record to evaluate the quality of the care provided to Jane. The health department also discussed Jane's care with an attorney.

4. Persons Involved in Your Care

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Officer at **202-835-2222**.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

Example: Jane's husband regularly comes to the health department with Jane for her appointments and he helps her with her medication. When the nurse practitioner is discussing a new medication with Jane, Jane invites her husband to come into the private room. The nurse practitioner discusses the new medication with Jane and Jane's husband.

5. Required by Law

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at **202-835-2222**.

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.

- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorizations

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission):

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

**YOU HAVE RIGHTS WITH RESPECT
TO MEDICAL INFORMATION ABOUT YOU**

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at **202-835-2222**.

1. Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at **202-835-2222**.

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out an **Access Request Form**. Access Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

Fee of \$25.00

We may be able to provide you with a summary or explanation of the information. Contact our Privacy Officer for more information on these services and any possible additional fees.

3. Right to Have Medical Information Amended

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Fee of \$25.00

5. Right to Request Restrictions on Uses and Disclosures

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

7. Right to Notification if a Breach of Your Medical Information Occurs

You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- A brief description of what happened;
- A description of the health information that was involved;
- Recommended steps you can take to protect yourself from harm;
- What steps we are taking in response to the breach; and,
- Contact procedures so you can obtain further information.

8. Right to Opt-Out of Fundraising Communications

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

**YOU MAY FILE A COMPLAINT
ABOUT OUR PRIVACY PRACTICES**

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

ORTHOPAEDIC MEDICINE AND SURGERY
1850 M Street NW | Washington, DC 20036 | (202) 835-2222

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

Office of Orthopaedic Medicine and Surgery, Attn: Chris Dugan
1850 M Street NW, Washington DC 20036

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

Email: OCRCComplaint@hhs.gov