ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

DATE: _____

Please use BLACK INK when completing this form

ACCOUNT #: _____

PATIENT INFORMATION

PLEASE PRINT CAREFULLY

PATIENT'S NAME (Last Name, First Name, Middle Name) | SOCIAL SECURITY NUMBER

PATIENT'S ADDRESS | DATE OF BIRTH ____/____/____ MM DD YYYY | GENDER ☐ MALE ☐ FEMALE

CITY | EMPLOYER

STATE | ZIP CODE | MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER

TELEPHONE (Include Area Code)
HOME WORK | PATIENT RELATIONSHIP TO PRIMARY INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SPOUSE: _____ | EMERGENCY CONTACT: _____ (not living in household)

SPOUSE'S EMPLOYER: _____ | RELATIONSHIP: _____

PHONE: _____ | PHONE: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

IS PATIENT'S CONDITION RELATED TO:

☐ YES ☐ NO EMPLOYMENT INJURY DATE _____

☐ YES ☐ NO AUTO ACCIDENT INJURY DATE _____

☐ YES ☐ NO OTHER ACCIDENT INJURY DATE _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

CITY _____ STATE _____ ZIP _____

EMPLOYER'S TELEPHONE: (____) _____

IF FULL-TIME STUDENT – SCHOOL: _____

CHIEF MEDICAL PROBLEM TODAY: _____ LEFT / RIGHT (INDICATE WHICH SIDE)

DATE SYMPTOMS BEGAN: _____

PLACE OF ACCIDENT: _____

HOW DID INJURY HAPPEN: _____

PRIOR TREATMENT FOR COMPLAINT: DATE: _____ PLACE & TREATING PHYSICIAN: _____

PRIOR X-RAYS FOR THIS PROBLEM: DATE: _____ PLACE: _____

INSURANCE INFORMATION

Your insurance cards will be requested for the registration process.

☐ PRIMARY INSURANCE

INSURED'S NAME _____ (Last, First, Mi)

SOCIAL SECURITY #: _____

INSURED'S EMPLOYER _____

INSURED'S DATE OF BIRTH _____

☐ SECONDARY INSURANCE

INSURED'S NAME _____ (Last, First, Mi)

SOCIAL SECURITY #: _____

INSURED'S EMPLOYER _____

INSURED'S DATE OF BIRTH _____

IF PATIENT IS A MINOR

FATHER'S NAME: _____

DATE OF BIRTH: _____ SS#: _____

FATHER'S EMPLOYER: _____

WORK PHONE: _____

MOTHER'S NAME: _____

DATE OF BIRTH: _____ SS#: _____

MOTHER'S EMPLOYER: _____

WORK PHONE: _____

ORTHOPAEDIC SPECIALISTS
History of Present Illness

Name: _____ **Age:** _____ **Date:** _____

For office use. Please leave this area blank

Location : _____
Where is your current pain/problem?

Duration: _____
How long have you had this pain/problem?

Context: _____
What were you doing at the onset of this pain/problem ?

Severity: _____
How severe is the pain on a scale of 1-10 with 10 being most severe?

Quality: _____
Is the pain sharp, dull, achy? If a lump, is it warm, red, tender?

Timing: _____
Does the pain occur at a specific time? Is it intermittent or constant ?

Radiates to: _____
Does the pain/problem travel to any other areas?

Aggravating Factors: _____
What makes the pain worse?

Relieving Factors: _____
What makes the pain better?

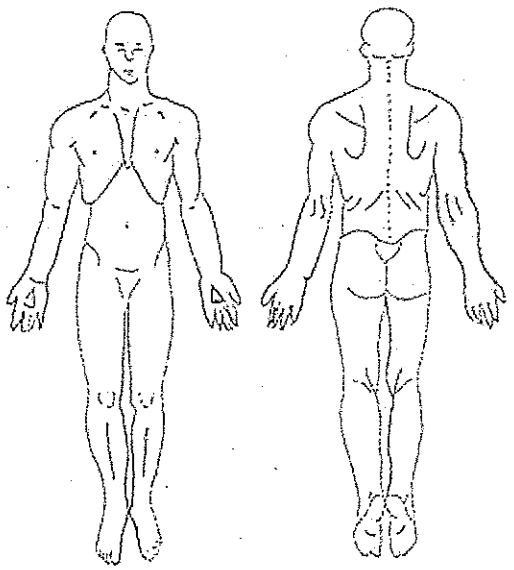
Associated Symptoms: _____
Any associated problems ? (numbness; bladder/bowel complaints; abnormal sounds – cracking, popping, grinding, clicking; swelling, stiffness, instability; night pain)

Have you seen any other physicians regarding **this** condition prior to coming to our office? □ **Yes** □ **No**

Doctor	When	Tests	Results	Treatment

Please mark on the drawings any areas where you feel discomfort. If you are not having any discomfort, leave blank and initial. Use the following key to show particular types of discomfort.

Burning pain: **xxxxxx**
Deep Ache: **oooooo**
Pins & needles: **//////////**
Stabbing pain: **zzzzzzz**



Have you ever experienced any prior injury or symptoms regarding this body part?
□Yes □ No
If so, please provide details:
_____
_____
_____
_____
_____
_____
_____

Overall, is the present discomfort
□ Getting better
□ Getting worse, or
□ Staying the same

Circle your **current level of BACK/NECK discomfort**

0---1---2---3---4---5---6---7---8---9---10
No pain — moderate pain — severe pain

Circle your **current level of ARM/LEG discomfort**

0---1---2---3---4---5---6---7---8---9---10
No pain — moderate pain — severe pain

Today's Date: _____

PATIENT MEDICAL HISTORY

Name: _____ Email address: _____

Age: _____ Height: ___' ___" Wt: _____lbs. Sex: □M □F

Are you? □ **Right-handed** □ **Left-handed**

CC / Reason for today's visit ? _____

Date of Injury or Onset of Symptoms: _____

Were you sent to our office by a physician? □ **Yes** □ **No** If so, please provide: **Is this work related?** □ **Yes** □ **No**

Requesting Physician's Name: _____ **Phone #:** _____
Physician's Address: _____ **City/State:** _____

MEDICATIONS: Include non-prescription & herbal supplements

Drug Name	Dosage	Frequency

ALLERGIES: □ **No** □**Yes** *(If yes, please list below)*

Medication	Reaction

Tape Allergy □**Yes** □**No** **Latex Allergy** □**Yes** □**N o**

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please check all pertinent boxes:*

□AIDS or HIV +□	□Bronchitis	□Hepatitis	□Mumps	□Thyroid Disease
□Anemia	□Chicken Pox	□High Blood Pressure	□Pneumonia	□Tuberculosis
□Arthritis	□Diabetes	□Infectious Mono	□Polio	□Ulcer
□Asthma	□Diphtheria	□Kidney Disease	□Rheumatic Fever	□Venereal Disease
□Back Trouble	□Epilepsy/Seizures	□Low Blood Pressure	□Scarlet Fever	□Whooping Cough
□Bladder Infections	□Glaucoma	□Measles	□Sleep Apnea	□Other (please list)
□Bleeding Tendency	□Heart Disease	□Migraine Headaches	□Smallpox	_____
□Blood Transfusions	□Hemorrhoids	□Mitral Valve Prolapse	□Stroke	_____

PAST SURGICAL/Hospitalization HISTORY:

Date	Surgery/Illness	Doctor	Hospital, City/State

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

PATIENT MEDICAL HISTORY

Patient Social History:

Marital Status	Living Situation	Use of Tobacco	Use of Alcohol
□Single	□With Family	□Never	□Never
□Married	□With Friends	□Previously, but quit	□Rarely
□Divorced	□Alone	□Currently	□Moderate
□Widowed	□Other	____Packs per day	□Daily
□ Separated			

OCCUPATION: _____

Review of Systems: Please indicate any personal history below: (Please circle all that apply.)

Musculoskeletal		Genitourinary		Psychiatric	
Joint Pain	No Yes	Frequent urination	No Yes	Memory loss or confusion	No Yes
Joint Stiffness or swelling	No Yes	Burning or painful urination	No Yes	Nervousness	No Yes
Weakness of muscles or joints	No Yes	Blood in urine	No Yes	Depression	No Yes
Muscle pain or cramps	No Yes	Incontinence or dribbling	No Yes	Insomnia	No Yes
Back pain	No Yes	Female – number pregnancies	_____		
Cold extremities	No Yes	Female – number of deliveries	_____	**Gastrointestinal**	
Difficulty in walking	No Yes			Loss of appetite	No Yes
				Nausea or vomiting	No Yes
Constitutional Symptoms		**Integumentary (skin, breasts)**		Frequent diarrhea	No Yes
Bad general health lately	No Yes	Rash or itching	No Yes	Constipation	No Yes
Recent weight change	No Yes	Changes in skin color	No Yes	Rectal bleeding, blood in stool	No Yes
Fever	No Yes	Varicose veins	No Yes	Abdominal pain	No Yes
Fatigue	No Yes	Breast pain	No Yes		
Headaches	No Yes	Breast lump	No Yes	**Respiratory**	
				Chronic or frequent coughs	No Yes
Ears/Nose/Mouth/Throat		**Neurological**		Spitting up blood	No Yes
Hearing loss or ringing	No Yes	Lightheaded or dizzy	No Yes	Shortness of breath	No Yes
Earaches or drainage	No Yes	Numbness or tingling sensations	No Yes	Wheezing	No Yes
Chronic sinus problems	No Yes	Tremors	No Yes		
Nose bleeds	No Yes	Paralysis	No Yes	**Eyes**	
Bleeding gums	No Yes			Eye disease or injury	No Yes
Sore throat or voice change	No Yes	**Endocrine**		Wear glasses/contact lenses	No Yes
Swollen glands in neck	No Yes	Excessive thirst or urination	No Yes	Blurred or double vision	No Yes
		Heart or cold intolerance	No Yes		
Cardiovascular		Skin becoming drier	No Yes	**Women:**	
Heart Trouble	No Yes			Irregular periods	No Yes
Chest pain or angina pectoris	No Yes	**Hematologic/Lymphatic**		Frequent spotting	No Yes
Palpitation	No Yes	Slow to heal after cuts	No Yes	Are you pregnant?	No Yes
Shortness of breath while walking	No Yes	Bleeding or bruising tendency	No Yes	(if over age 18)	
Swelling of feet, ankles or hands	No Yes	Anemia	No Yes	Are you nursing?	No Yes
		Enlarged glands	No Yes		

Have you ever experienced any prior injury or symptoms regarding this body part? □Yes □ No
If so, please provide details: _____

Please list any sports/hobbies you enjoy: _____

LEGAL INFORMATION:

Is there any current or pending litigation involving this problem for which we are seeing you today? □Yes □No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

X _____ _____

Signature of Patient or Parent if Minor Date Signature of Physician Date

ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

PATIENT MEDICAL HISTORY

Date _____

Update _____

Update _____

Update _____

NAME _____

HAVE YOU EVER RECEIVED TREATMENT FOR?			IF YES, EXPLAIN
Mental Illness	☐ Yes	☐ No	_____
HIV Positive / AIDS	☐ Yes	☐ No	_____
Sexually Transmitted Disease(s)	☐ Yes	☐ No	_____
Alcohol Abuse	☐ Yes	☐ No	_____
Illicit Drug Use	☐ Yes	☐ No	_____
Are you currently Pregnant and under age of 18?	☐ Yes	☐ No	_____

If you have answered ***Yes*** to any of the above, ***please initial*** the corresponding categories listed below which will authorize Orthopaedic Specialists to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law.

Initials: _____ Mental Illness Information

Initials: _____ HIV / AIDS Information

Initials: _____ Sexually Transmitted Disease(s) Information

Initials: _____ Alcohol Abuse Information

Initials: _____ Illicit Drug Use Information

Initials: _____ Pregnancy Information, if patient is under the age of eighteen (18)

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

By signing below, I acknowledge and agree to the above conditions. DATE _____

X _____
SIGNATURE OF PATIENT
(OR AUTHORIZED REPRESENTATIVE*)

_____
PRINT NAME OF PATIENT
(OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

_____

_____

_____
Physician Signature

_____
Date

ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

Please use BLACK INK when completing this form

ASSIGNMENT OF BENEFITS AND DIRECTION FOR PAYMENT

Patient: _____ Insurance Co: _____ (Primary)

Account #: _____ Insurance Co: _____ (Secondary)

I hereby instruct and direct the above named insurance company to pay by check made payable to:

ORTHOPAEDIC SPECIALISTS OF MIAMI BEACH
4701 MERIDIAN AVENUE • ADAMS BUILDING • SUITE 601
MIAMI BEACH, FLORIDA 33140

The medical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the Services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Orthopaedic Specialists of Miami Beach and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment except to the extent my liability for any such balance is limited by agreement or law applicable to the Orthopaedic Specialists of Miami Beach.

A photocopy of this assignment shall be considered as effective and as valid as the original. I also authorize the release of any information acquired in the course of my treatment to any insurance company, adjuster or attorney involved in this case.

DATE _____

X _____ _____

SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) — PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED

If I, _____, receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, award by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to:

ORTHOPAEDIC SPECIALISTS OF MIAMI BEACH
4701 MERIDIAN AVENUE • ADAMS BUILDING • SUITE 601
MIAMI BEACH, FLORIDA 33140

to the extent of any outstanding amounts then owed by me to the Orthopaedic Specialists of Miami Beach for medical services before any other fees, costs, or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by the Orthopaedic Specialists of Miami Beach depends on the treatment rendered and that any amount that I owe to the Orthopaedic Specialists of Miami Beach shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, award, jury verdict or insurance proceeds that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to the Orthopaedic Specialists of Miami Beach shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties.

I hereby appoint the Orthopaedic Specialists of Miami Beach or its designee as my attorney-in-fact to sign my name to and file a financing statement under the Uniform Commercial Code to evidence this lien.

I understand that I remain personally responsible for the payment of all fees owed by me to the Orthopaedic Specialists of Miami Beach and that notwithstanding this Assignment and Lien, the Orthopaedic Specialists of Miami Beach is not required to look to any other person or entity for payment.

I will instruct my attorney to pay the Orthopaedic Specialists of Miami Beach as provided above from any monies received by him/her described above. These instructions are irrevocable and may not be changed without the written agreement of the Orthopaedic Specialists of Miami Beach. I have given authorization to the Orthopaedic Specialists of Miami Beach to forward this document to my attorney.

DATE _____

X _____ _____

SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) — PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

PHILIP LOZMAN, M.D.

JERRY SHER, M.D.

SOPHIA DEBEN, M.D.

MALPRACTICE COVERAGE

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who failed to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law. Florida Statutes 458.320 7(b)(II) 5.

X _____
Signature

_____
Name

_____
Date

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: X _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ___/___/___

HIPAA Notice of Privacy Practices

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.

About This Notice

This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

How We May Use and Disclose Your Protected Health Information

The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

For Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

For Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for hospital admission.

For Health Care Operations
We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services
We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Fundraising Activities
We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

Plan Sponsors
If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

Facility Directories
Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people

that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Required by Law
We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health
We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Business Associates
We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Communicable Diseases
We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect
We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration
We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

Legal Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement
We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation
We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity
Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security
When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates
We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

For Data Breach Notification Purposes
We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan, if applicable, through which you receive coverage.

Required Uses and Disclosures
Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.

Your Rights Regarding Health Information About You

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled 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. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.

Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

This office is not required to agree to a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket. If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the third party payer.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You have the right to receive notice of a security breach. We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Complaints or Questions

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. You may reach our office by calling: (_____) _____ .
Telephone

If you have a question about this privacy notice, please contact our Privacy Officer at: (_____) _____ .
Telephone

Effective Date: This notice is effective as of 9/23/2013.