ALPINE ORTHOPAEDIC SPECIALISTS
FINANCIAL POLICY

Thank You for choosing Alpine Orthopaedic Specialists as your Health Care Provider. We are committed to giving you excellent medical treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. All patients must complete our "patient information forms" before seeing the doctor.

CONSENT TO TREAT: I consent to treatment at Alpine Orthopaedic Specialists for services or supplies that have been or may be ordered by the physician. I understand that treatment may include but is not limited to; radiological examinations, injections, laboratory procedures, physical therapy, nursing care, braces, orthotics, crutches, or medical and surgical treatment. I acknowledge that the clinic has not made nor can it make a guarantee of the outcome of treatment.

SELF PAY: Payments on all accounts without insurance are due at the time the service is rendered. A discount is given with payment in full. Monthly budget plans are available if arrangements have been made with the business office and Self Pay Financial Policy has been completed.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will submit claims to your insurance carrier if you have provided us with all the pertinent information to process a claim. We will extend credit for 60 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. After 60 days if your insurance has not paid your account in full, we require that you pay the balance. You are also responsible for all deductibles, co-payments, and charges not covered by insurance. I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

LIABILITIES: Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility. We will extend credit for 60 days on liability accounts only if we have the necessary information to exercise our third party rights. If you cannot provide this information, your account is due at the time of service. If your claim has been denied or benefits exhausted the balance is your responsibility and payment in full is required at that time. If your claim is settled and made payable to us any overpayment by you will then be refunded.

UNPAID ACCOUNTS & INTEREST CHARGES: In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all collection agency fees, court costs, and reasonable attorneys fees incurred. We reserve the right to charge interest at the rate of 1 ½ % per month, 18% annually.

CREDIT OPTIONS AVAILABLE: We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and DEBIT CARDS.

I acknowledge that I have reviewed the notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request. (initials) __________.

*****I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY*****

PATIENT NAME (please print) **DATE**

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **PRINTED NAME**

In Case of Emergency Please Contact:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

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HEALTH HISTORY FORM

Name: ______________________ Phone: ______________ Birth Date: ________ Date: __________

What problem are you being seen for today? ______________________________

Date/Place/When/How Occurred: ______________________________

Primary Care Physician: ______________________ Referred By: ______________

Prior Treatment: ☐ Yes ☐ No Prior x-rays? ☐ Yes ☐ No

Patient Signature: ______________________________

DRUG ALLERGIES

____

CURRENT MEDICATIONS

Medication	Dosage

WORK AND SOCIAL HISTORY

Occupation: ______________________________

Does your work involve heavy lifting?	☐ Yes	☐ No
Standing for long periods of time?	☐ Yes	☐ No
Sitting for long periods of time?	☐ Yes	☐ No

What do you do for exercise? ______________________________

Smoking Status? ☐ Current Never ☐ Previous

Alcohol Drinks Per Day? ☐ Non-Drinker ☐ 1-2 ☐ 3 or More

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please check if you have a past medical history of the following:

☐ Allergies ______	☐ Depression ______	☐ Kidney Disease ______
☐ Anemia ______	☐ Diabetes ______	☐ Pneumonia ______
☐ Anesthetic problems ______	☐ Frequent infections ______	☐ Prostate disease ______
☐ Arthritis ______	☐ Digestive disorder/Ulcer ______	☐ Osteoporosis ______
☐ Asthma ______	☐ Gout ______	☐ Tetanus ______
☐ Blood Clot/DVT ______	☐ Heart problems ______	☐ AIDS/HIV ______
☐ Cancer/What Type ______	☐ Hepatitis ______	☐ Tuberculosis/TB ______
☐ Chronic rashes ______	☐ High Blood Pressure ______	☐ Thyroid Disease ______

FAMILY MEDICAL HISTORY: Please mark any of the conditions that your mother (M), father (F), brother (B), or sister (S) has or had

☐ Heart disease	☐ Diabetes ______	☐ Osteoporosis ______
☐ High blood pressure	Arthritis ______	Other ______
☐ Bleeding problems	Cancer	

REVIEW OF SYMPTOMS

Please check if you are currently experiencing any of the following symptoms:

☐ Fever	☐ Bladder incontinence	☐ Blood in Stools	☐ Numbness
☐ Chills	☐ Diarrhea	☐ Abdominal pain	☐ Tingling
☐ Night sweats	☐ Constipation	☐ Headaches	☐ Weakness
☐ Unexplained weight loss	☐ Nausea	☐ Blurred Vision	☐ Chest pain
☐ Bowel incontinence	☐ Wheezing	☐ Joint Pain	☐ Palpitations
☐ Shortness of breath	☐ Vomiting	☐ Difficulty swallowing	☐ Other

PHYSICIAN'S USE

Reviewed by: Date: Reviewed by: Date:

Reviewed by: Date: Reviewed by: ______________ Date:

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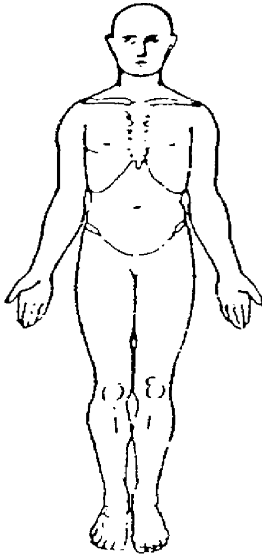
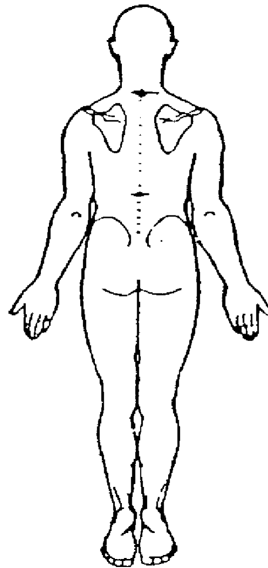
History Form

1. Please mark on the following diagram where your pain is, and use the key for pain types:





Key:

**** Tingling

----- Stabbing

⟶ Radiating

///// Aching

ΔΔΔ Burning

2. When did your current episode of pain begin? ______________________________

3. What do you think caused your current pain? ______________________________

____

4. Have you had pain in this area previously? Please circle. Yes or No

5. If you answered yes, when and how did your original pain develop? ______________________________

____

6. How bad is your pain on a scale from 0 (no pain) to 10 (worst pain imaginable) when it is its worst? ____________

When it is its best? ____________ On average? ____________

7. What makes your pain worse (types of activities and body postitions)? ______________________________

____

8. What helps improve your pain? ______________________________

____

9. Please list the names of medications you have taken to try and treat the pain. ______________________________

____

10. Please circle any of the following treatments you have tried. Physical therapy, chiropractics, massage, acupuncture, TENS unit, heat, ice, traction, braces, splints, orthotics.

11. If you have had surgery for this problem in the past, please list the dates and types of surgery. ____________

____

12. If you have tried other forms of treatment, please list them. ______________________________

____

Effective Date: *September 23, 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.

If you have any questions about this notice, please contact The Alpine Orthopaedic Specialists, Clinical Director.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the orthopaedic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose 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 to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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 Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

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

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to The Alpine Orthopaedic Specialists, Clinical Director. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or
format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have 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 or for our office. To request an amendment,
you must make your request, in writing, to The Alpine Orthopaedic Specialist, Clinical Director.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to The Alpine Orthopaedic Specialists, Clinical Director.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to The Alpine Orthopaedic Specialists, Clinical Director. We are not required to agree to your request 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 have paid us "out- of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to the Clinical Director of Alpine Orthopaedic Specialists. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.alpineortho.com. To obtain a paper copy of this notice, please ask at the front desk, or mail a request to The Alpine Orthopaedic Specialists, Clinical Director.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

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 Alpine Orthopaedic Specialists, Clinical Director. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

Notice of Privacy Practices, 2013 revised