 **PATIENT INFORMATION FORM**

**Complete all questions below and on the following pages. Please print clearly.**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Full name as printed on your INSURANCE card)**

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gender:** **M / F** **Marital Status:** **M / S / D / W**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ST:** \_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(If a minor, please list a parent’s cell # and which parent)**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer or School Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Job or Grade:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN / SOURCE INFO:**

Referring Physician or how you heard about us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GUARANTOR INFORMATION FOR BILLING:**

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Insurance Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Person who holds the policy)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

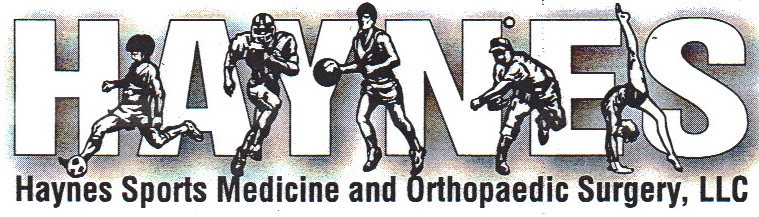
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHARMACY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Room: \_\_\_\_\_\_\_\_\_\_\_

CD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# New Patient

Height: \_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_lbs.

B/P: \_\_\_\_\_/\_\_\_\_\_

### APPOINTMENT

### INFORMATION

## 

Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician and/or Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Reason for today visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Body Part being seen for today)

Is this the result of an: INJURY or MVA=Motor Vehicle Accident or N/A

Date of Injury/Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you injured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What were the circumstances surrounding the injury/accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not an injury, how long has this problem been present? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has another physician treated you for this problem? YES NO

If YES, please list physician’s name, address and phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have any prior X-rays taken before today, for this same issue? YES NO

(Not the ones you just took at Medcross Imaging PC. Did you have others made at another time or place?)

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you visit the Emergency Room for this problem? YES NO

If YES, which ER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

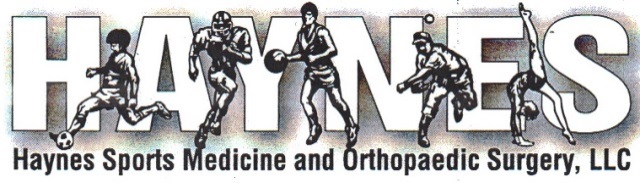
Date of ER Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeking a second opinion? YES NO

For radiology purposes, are you currently pregnant? YES NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of PATIENT/GUARDIAN Date**



**REVIEW OF SYMPTOMS**

**Only circle the symptoms that currently apply to you:**

**GENERAL:**

Fever – Chills – Sweats – Anorexia – Fatigue – Sleepiness – Sleep Problems – Malaise – Weight Gain – Weight Loss – Speech Delay

**EYES:**

Eye Pain – Vision Loss – Excessive Tears – Blurring – Diplopia (Double vision) – Irritation – Discharge – Photophobia (Light sensitivity)

**EAR/NOSE/THROAT:**

Ear Pain/discharge – Tinnitus/ringing – Decreased hearing – Nasal Obstruction/discharge – Nosebleeds – Sore throat – Hoarseness

Dysphagia (Difficulty swallowing)

**CARDIOVASCULAR:**

Chest pain – Palpitation – Syncope (fainting) – Dyspnea (difficulty breathing on exertion) – Peripheral Edema (swelling) -

Orthopnea (difficulty breathing while laying down) – PND (difficulty breathing after waking up)

**RESPIRATORY:**

Cough – Dyspnea – Excessive Sputum – Hemoptysis (coughing up blood) – Wheezing

**GASTROINTESTINAL:**

Nausea – Vomiting - Diarrhea – Constipation – Abdominal pain – Jaundice - Change in bowel habits - Melena (black stool) –

Hematochezia (bloody stool)

**MUSCULOSKELETAL:**

Back pain – Joint pain – Joint swelling – Muscle cramps – Muscle weakness – Stiffness

**SKIN:**

Rash – Itching – Ulcers/growths – Excess scarring – Bleeding problem – Dryness – Suspicious lesions

**NEUROLOGIC:**

Transient paralysis – Weakness – Paresthesia – Seizures – Syncope – Tremors – Vertigo

**PSYCHIATRIC:**

Depression – Anxiety – Memory loss – Mental disturbance – Suicidal ideation – Hallucinations – Paranoia

**ENDOCRINE:**

Cold intolerance – Heat intolerance – Polydipsia (excess thirst) – Polyphagia (excess hunger) – Polyuria (excess urine volume)

**LYMPHATIC:**

Abnormal bruising – Bleeding – Enlarged lymph nodes

**ALLERGIC/IMMUNOLOGIC:**

Uticaria (hives) – Hay fever – Persistent infections – HIV/AIDS exposure – Hepatitis A, B, C, D, E or G exposure

**HEALTH SCREENING:**

Colonoscopy – Mammogram – Pap smear

**FEMALES only:**

Vaginal discharge or sores – Menstrual irregularity – Urinary incontinence – Dysuria (painful urination) – Hematuria (blood in urine)

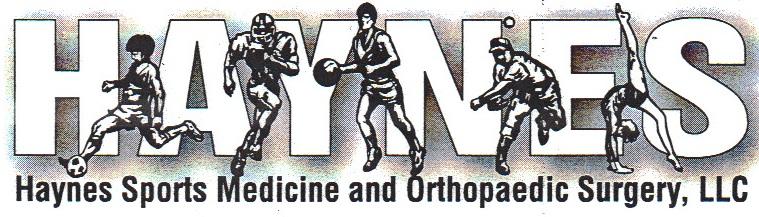
**MALES only:**

Dysuria (painful urination) – Nocturia (urination at night) – Hematuria (blood in urine) –Urinary hesitancy - Urinary incontinence –

Genital sores – Discharge - Impotence

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICAL HISTORY QUESTIONNAIRE**

**PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Please **initial** if either you, your Mother and/or your Father currently have or have ever had any of the following conditions, and state **who** had it:

**Y=YOU M=MOTHER F=FATHER**

\_\_\_\_\_ Alcoholism \_\_\_\_\_ Allergic Rhinitis

\_\_\_\_\_ Anemia \_\_\_\_\_ Anesthesia Problems

\_\_\_\_\_ Anxiety \_\_\_\_\_ Arthritis

\_\_\_\_\_ Asthma \_\_\_\_\_ Atrial fibrillation

\_\_\_\_\_ Bleeding Disease \_\_\_\_\_ Chest pain

\_\_\_\_\_ Circulatory System Disorder \_\_\_\_\_ Congestive Heart Failure

\_\_\_\_\_ Depression \_\_\_\_\_ Diabetes

\_\_\_\_\_ Emphysema \_\_\_\_\_ Esophageal Reflux (GERD)

\_\_\_\_\_ Gastric Ulcer \_\_\_\_\_ Gout

\_\_\_\_\_ Headaches \_\_\_\_\_ Hearing Loss

\_\_\_\_\_ Heart Attack \_\_\_\_\_ Heart Disease

\_\_\_\_\_ Herniated Disc \_\_\_\_\_ Heartburn

\_\_\_\_\_ High Blood Pressure \_\_\_\_\_ High Cholesterol

\_\_\_\_\_ High Lipids \_\_\_\_\_ Hypothyroid

\_\_\_\_\_ Insomnia \_\_\_\_\_ Irritable Bowel Syndrome

\_\_\_\_\_ Kidney Disease/Failure \_\_\_\_\_ Kidney Stones

\_\_\_\_\_ Migraines \_\_\_\_\_ Mitral Valve Disorder

\_\_\_\_\_ Osteoporosis \_\_\_\_\_ Rotator Cuff Tear

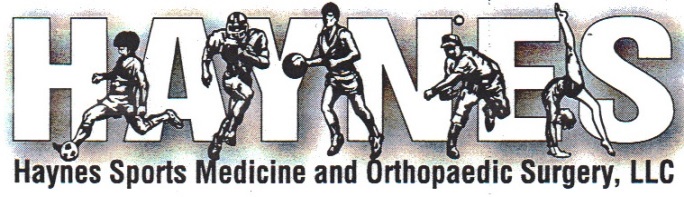
\_\_\_\_\_ Seizures \_\_\_\_\_ Sinusitis

\_\_\_\_\_ Skin Disorder \_\_\_\_\_ Smoking

\_\_\_\_\_ Stroke \_\_\_\_\_ Visual Impairment

\_\_\_\_\_ Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MEDICAL HISTORY QUESTIONNAIRE**

**PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS including the strength and dosage:**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICATION ALLERGIES:**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST SURGICAL HISTORY AND DATES:**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY:**

**Marital Status: S / M / D / W Alcohol Use: Y / N Tobacco Use: Y / N Drug Use: Y / N**

**Type: \_\_\_\_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Quit: \_\_\_\_\_\_\_\_\_**

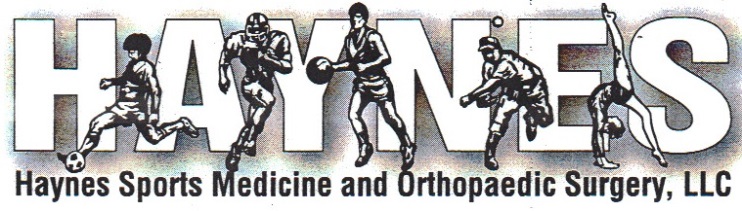
**OCCUPATION / EMPLOYMENT:**

**Employer or School Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation or Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you injured at work? Y / N If yes, did you notify your employer of the injury? Y / N**

**If yes, when was your last date of work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

** PATIENT FINANCIAL POLICY**

It is the goal of Haynes Sports Medicine and Orthopaedic Surgery to provide the highest quality of medical care to our patients. As a courtesy to our patients, we are providing you with this written policy of financial responsibility.

Your insurance coverage is a contract between yourself and the insurance company**. It is your responsibility to be sure of proper coverage before being seen by our physician.** This includes providing our office with the proper referral, if required by your insurance coverage. As a general policy, our office does not file any third party insurance (auto, home owners, or other liability insurance). However, in the case of a motor vehicle accident, our office will file auto insurance if provided with the proper documentation to do so. In all other cases, we are happy to assist you with obtaining all needed documentation for you to file these yourself, and we do expect payment from you when services are rendered.

As a courtesy, we will file these bills with your insurance(s) in a timely fashion, but keep in mind that with most insurance plans, there is a portion of fees that are the patient’s responsibility. Prompt payment of these fees is both expected and appreciated.

While we participate with a host of insurance companies, most plans that we do not participate with do have out-of-network benefits that allow the patient outside the network coverage at a much-reduced rate. In this event, you will responsible for the difference between what you plan pays and our fee schedule.

If the patient is a minor, payment for all services rendered will be expected from the guardian or parent that escorts the patient to their appointment.

**If for any reason your insurance coverage changes or other coverage is added, please notify us as soon as possible, to avoid excess cost to you and make for a smooth transition of coverage.**

Charges that are found to be the patient’s responsibility will be mailed to you on a detailed statement. If no action is taken on your behalf to meet your financial responsibility, your account will be turned over to a collections agency.

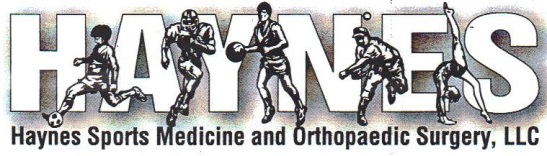
In the event that an account is turned over to a collection agency, the patient will be responsible for any collections fees, attorney’s fees, etc. Any NSF and returned checks will be assessed a $25 charge. Also, in the event that your private insurance has not reimbursed our facility for services rendered after sixty days from the date we file your claim, the patient/or the guarantor, may be responsible for the full payment of the services rendered

**By signing this waiver, you authorize the release of all medical information pertinent to your medical care and necessary to the processing of your insurance claims. Also, you authorized the assignment of all medical benefits to Haynes Sports Medicine and Orthopaedic Surgery, LLC.**

**I have read the above policies in their entirety. I do understand and agree to all of them.**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Guardian or Parent Signature if Patient is a Minor)**

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**2017 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.**

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:** The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at HAYNES SPORTS MEDICINE (the Practice) may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HAYNES SPORTS MEDICINE or the hospital. For example, we may disclose medical information about you to people outside HAYNES SPORTS MEDICINE who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

**For Healthcare Operations:** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run HAYNES SPORTS MEDICINE and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other HAYNES SPORTS MEDICINE personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE:** This notice describes HAYNES SPORTS MEDICINE policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group, which we allow to help you, as well as all employees, staff and other HAYNES SPORTS MEDICINE personnel.

**POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION:** We create a record of the care and services you receive at HAYNES SPORTS MEDICINE. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by HAYNES SPORTS MEDICINE, whether made by HAYNES SPORTS MEDICINE personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

**NOTICE OF INDIVIDUAL RIGHTS**

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

**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.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, HAYNES SPORTS MEDICINE. To request an amendment, your request must be made in writing and submitted to the Practice Manager and you must provide a reason that supports your request. We may deny your request for an amendment.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Practice Manager.

**Right to Request Removal from Fundraising Communications.** You have the right to opt out of receiving fundraising communications from the HAYNES SPORTS MEDICINE. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

**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. You must make your request in writing and you must specify how or where you wish to be contacted.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. **CHANGES TO THIS NOTICE**. We reserve the right to change this notice. We will post a copy of the current notice in the HAYNES SPORTS MEDICINE front office. **COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint with HAYNES SPORTS MEDICINE or with the Secretary of the Department of Health and Human Services. To file a complaint with HAYNES SPORTS MEDICINE, contact Laura Haynes, Practice Manager, 678-513-8111 at 11459 Johns Creek Parkway, Ste 240, Johns Creek, GA 30097.All complaints must be submitted in writing. **You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Practice Manager at HAYNES SPORTS MEDICINE.

**I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name Signature of Patient or Parent/Guardian if Patient is a Minor Date**