VERO ORTHOPAEDICS / VERO NEUROLOGY

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. <u>PLEASE REVIEW IT CLOSELY.</u>

<u>**Uses & Disclosures**</u>

Treatment. Your health information may be used by staff members or disclosed to other health care professions for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of Vero Orthopaedics/Vero Neurology. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses & Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed-above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

<u>**Additional Uses of Information**</u>

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about Treatment. Your health information may be used to send you information on the treatment and management of your medical condition that we may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights. You have certain rights under federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information at your cost
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and whom your protected health information has been disclosed
- the right to receive a printed copy of this Notice

Vero Orthopaedics/Vero Neurology Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Privacy Officer. There may be a charge for this service.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Vero Orthopaedics/Vero Neurology
1155 35th Lane, Suite 100
Vero Beach, Florida 32960

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person. The name and address of the person you can contact for further information concerning our privacy practice is as-noted above, or telephone numbers is (772) 569-2330.

Effective Date. This Notice is effective on or after January 13, 2003

VERO ORTHOPAEDICS / VERO NEUROLOGY

CONSENT TO USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Vero Orthopaedics/Vero Neurology or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Vero Orthopaedics/Vero Neurology may or may not agree to restrict the use or disclosure of your protected health information.

If Vero Orthopaedics/Vero Neurology agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke tis consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Vero Orthopaedics/Vero Neurology reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Vero Orthopaedics/Vero Neurology to use and disclose my health information in accordance with it.

____
Name of Patient (Type or Print)

____
Signature of Patient   Date

____
Signature of Patient Representative / Relationship to Patient   Date

Welcome to Our Office

NEW PATIENT INFORMATION

VERO ORTHOPAEDICS / Vero Neurology

1. PATIENT NAME	12. _______ MARRIED _______ SINGLE _______ WIDOWED
2. ADDRESS	13. _____ PART TIME STUDENT _____ FULL TIME STUDENT _____ UNEMPLOYED _____ EMPLOYED _____ RETIRED _____ OTHER
3. CITY, STATE	
4. ZIP CODE	14. REFERRING PHYSICIAN
5. TELEPHONE NO.	15. IF NOT REFERRED BY A PHYSICIAN, WHO REFERRED YOU: _____ FRIEND ? NAME: ___________________________ _____ NEWSPAPER _____ RADIO _____ COMMUNITY EVENT: _________________________ _____ YELLOW PAGES _____ OTHER: _____________________________________
6. VERO ORTHO PHYSICIAN	
7. SOCIAL SECURITY NO.	
8. EMPLOYER NAME & ADDRESS	
9. EMPLOYER PHONE NUMBER	
10. PATIENT SEX / 11. BIRTHDATE	

FINANCIALLY RESPONSIBLE PERSON (If different than above)

1. FINANCIALLY RESPONSIBLE PERSON (NAME): / RELATIONSHIP TO PATIENT	6. EMPLOYER NAME	
2. ADDRESS	7. EMPLOYER ADDRESS	
3. CITY, STATE	8. EMPLOYER PHONE NO.	
4. ZIP CODE	8. SOCIAL SECURITY NO.	
5. TELEPHONE NO.	9. BIRTHDATE	10. SEX
OTHER ADDRESS? (SEASONAL)		

INSURANCE COMPANY INFORMATION

Address Required In Order To File

1. PRIMARY INSURANCE COMPANY NAME		5. ADDRESS
2. HOLDER OF POLICY	BIRTHDATE	6. CITY, STATE ZIP
3. POLICY NO.	4. GROUP NO.	
1. SECONDARY INSURANCE COMPANY NAME		5. ADDRESS
2. HOLDER OF POLICY	BIRTHDATE	6. CITY, STATE ZIP
3. POLICY NO.	4. GROUP NO.	

Physician Signature ______________________ Date

Patient Signature ______________________ Date

Please fill out completely. VERO ORTHOPAEDICS / **Vero Neurology** DATE ____________________

Patient Name: ________________________________ DOB __________ Age _____ Occupation: ______________________
(Present /Prior)

Referring M.D. ____________________________________ Name of Family M.D. ________________________________

Describe the problem you are being seen for today: ____

Date of Injury: ____________________________ Pharmacy Name: ____

Emergency Contact: Name: ____________________________ Telephone Number ________________ Relationship ________________

Are you Disabled? _____ Job Related _____ Military _____

Is this work related? Yes _____ No _____

Were you seen in the Emergency Room? Yes _____ No _____

Lawsuit involved? Yes _____ No _____

Have you been previously treated for this problem? Yes _____ No _____

Have you had recent X-Ray studies? Yes _____ No _____

Where? __________________________________

PATIENT HISTORY

____ Anemia
____ Arthritis
____ Rheumatoid Arthritis
____ Asthma
____ Neck or Back Disorders
____ Bursitis
____ Bleeding Diseases
____ Cancer Where / Date ___________

____

____ Diabetes
____ Heart Disease / MI
____ Hepatitis
____ High Blood Pressure
____ HIV / AIDS
____ Kidney Infection
____ Kidney Stone
____ COPD
____ Lyme Disease
____ Phlebitis
____ Pneumonia
____ Rheumatic Fever
____ Stroke -TIA
____ Thyroid Disease
____ TB
____ Other ____________________

____

REVIEW OF SYSTEMS

____ Headaches
____ Prior Problem / Risk of Anesthesia
____ Sinusitis
____ Loss of Hearing
____ Peptic Ulcer
____ Stomach Pain
____ Bowel Disease (i.e. Colitis, Diverticulitis)
____ Intestinal Bleeding
____ Frequent Urination
____ Burning on Urination
____ Difficulty Starting Urination
____ Shortness of Breath
____ Chills or Fever
____ Heart/Chest Pain - Angina
____ Abnormal Heart Beat
____ Muscle Weakness
____ Joint Pain / Stiffness
____ Joint Swelling
____ Calf Cramps When Walking
____ Recent Weight Loss
____ Leg / skin Ulcers
____ Mental Illness
____ Cold / Heat Intolerance
____ Dizziness / Vertigo
____ Double Vision
____ Extremity Numbness
____ Gout
____ Psoriasis
____ Addiction

SOCIAL HISTORY

Married _____ Single _____Widowed _____

Number of Children Living? ________

Presently living alone? Yes _____ No _____

Do you smoke? Yes ____ No ____ Never ____

If no, when did you quit? ________________

Alcohol: Never _____ Occasional ______

Moderate to Heavy ______

Drug Overuse: Never ______

Present Problem ______ Past Problem ______

Exercise? Yes ______ No ______

Interests / Hobbies: ____________________

____

PREVIOUS SURGERIES

____ None
____ Tonsils
____ Gallbladder
____ Appendix
____ Prostate
____ Hysterectomy
____ Cancer
____ Back: cervical _____ lumbar _____
____ Fracture
____ Other, Please list: _______________

____

FAMILY HISTORY

If a member of your family has had a history of any of the following conditions please put a check on the line

____ Stroke
____ Heart Disease
____ High Blood Pressure
____ Diabetes
____ Arthritis
____ Gout
____ Seizure
____ Mental Illness
____ Kidney Disease or Stones

____ Cancer
____ Bleeding Disorders
____ Alcoholism
____ Addiction
____ HIV/Aids
____ Leukemia
____ Other

Major cause of death:

	Mother	Father
Cancer	____	____
Diabetes	____	____
Heart Disease	____	____
Hypertension	____	____
Accident	____	____

*Please explain all Yes answers:*________________________________

____

____

______________________________ ______________________________
Physician Signature Date Patient Signature Date

VERO ORTHOPAEDICS / VERO NEUROLOGY

PATIENT: ____ **DOB:** ___________________ **DATE:** __________________

ARE YOU ALLERGIC TO LATEX? ______________________________________

ALLERGIES

PLEASE LIST (PRINT) ALL CURRENT MEDICATIONS, DOSAGE & FREQUENCY

____ ____

Physician Signature Date Patient Signature Date