ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

Dear Patient:

Welcome to the practice. We are honored that you have chosen us for your care, and we are committed to providing you with the best care we can. Our hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. We will share our medical expertise with you, and we hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being.

You trust us to care for the most important thing you have- your health. At Orthopaedic Associates we are dedicated to providing the best in orthopedic care to people from all walks of life and all ages. We want help you regain the ability to choose your own activities. The team approach to helping you heal from your orthopedic problem is the key to our method. Years of experience with patients who have work injuries, sports injuries, accidents, fractures, or the effects of aging have allowed us to develop a customized solution to your problem. While many patients are best treated without surgery, rest assured, if surgery is needed, we have the experience to help you be the best you can be. Our extensive experience, particularly in shoulder surgery and knee surgery, is to your benefit.

While we enjoy spending time with you, there are a few housekeeping notes to help decrease the length of time you spend at the office:

1. Bring all of your workman's compensation authorizations, claims numbers and insurance information.
2. Have photo identification (current driver's license, employee badge or military identification card
3. Bring all medications you are currently taking, including vitamins and over the counter medications. If you bring a list, please make sure it is current. This will ensure your medication list is accurate and current with correct dosages and dosing instructions.
4. Please complete the attached forms prior to your arrival.
5. If you are having a problem with your shoulder please wear or bring a tank top and/or sports bra to wear during the examination. If you are having a problem with your hip/knee/foot, please bring a pair of shorts to wear during the examination.

While workman's compensation does have its own rules that we must follow, we are your doctor. You are our patient and you will be treated with the respect you deserve. We are pleased to be at your service.

The Team at Orthopaedic Associates

# New Problem History

Today's Date:_____

Your Name:_____

Birthdate:_____

Why do you want to see the Doctor?

What were you doing the first time it hurt?_____

Where is the problem?_____

How long has it been bothering you?_____

When does it bother you?_____

_____

On a scale of 1-10 how bad is it?_____

What is the pain like?_____

What makes the problem better?_____

What makes the problem worse?_____

Are other things associated with the problem?_____

_____

Have you had this problem before?_____When?_____

Who treated you then?_____

Have you had any tests done?

| Type of Test | When? | Where? | What did it show? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you seeing another doctor having any other problems with your health ?

| Diagnosis? (Diabetes, Blood Pressure, Heart Attack?) | Are you using medicine? | What is the name of the medicine? | Who is the doctor treating you for this? |
|---|---|---|---|
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Are you using any other medicines? Please include over the counter or natural meds

| Medicine Name | Dosage | How Often | When did you start? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |

Is there anything else the doctor should know?

I have answered the questions truthfully and as best I can

Signature:_____ Date:_____

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

# PATIENT MEDICATIONS and ALLERGIES

Name_____ Date of Birth_____

Today's Date_____

## ALLERGIES

| Medication | Reaction (What goes wrong when you use the medicine?) |
|---|---|
| | |
| | |
| | |
| | |
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## CURRENT MEDICATIONS

| Medication | Dosage | How Often? | For What Condition? |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |
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| | | | |

Signature:_____ Date _____

# COMPREHENSIVE HISTORY: PATIENT FORM

Today's Date:

Name

Age Date of Birth Sex Race
Place of Birth Marital Status Occupation
Who referred you here?

## Past Medical History

**General State of Health** Excellent, good, fair, poor (circle one)

**Childhood illnesses:** measles, German measles, mumps, whooping cough, chickenpox, rheumatic fever, scarlet fever, polio (circle those you have had)

**Psychiatric illnesses:**

**Immunizations:** When was your last tetanus shot_____ , pertussis, diphtheria, polio, measles, German Measles, mumps, hepatitis A, hepatitis B, cholera, typhoid (circle those you have had)

### Operations/Surgery

| Procedure (what did they do?) | When was it done? | Surgeon | Hospital |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Background History

Schooling; highest grade completed _____
Military Service _____
Job History _____
Marriage_____
Retirement_____

## Fractures (broken bones)

| Which Bone? | When? | Doctor? | Problems now? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |

## Family History

| | Age | Illness, Disability, Cause of Death |
|---|---|---|
| **Mother** | | |
| **Father** | | |
| **Spouse** | | |
| **Child** | | |
| **Child** | | |
| **Child** | | |
| **Child** | | |

***The occurrence within the family* of *any of the following conditions*** *(please circle all that apply):* Diabetes, tuberculosis, heart disease, high blood pressure, stroke, kidney disease, cancer, arthritis, Anemia, headaches, mental illness, symptoms like those you are having, blood clots, bleeding problems

## Social History

Diet: excellent, good, fair, poor (circle)
Sleep: excellent, good, fair, poor (circle)
Exercise: regular, sometimes, rarely (circle) type:_____
Use of coffee/tea:_____ cups per day
Alcohol: Type _____ How often? _____ How much? _____
Other Drugs: Type _____
Tobacco: Type_____ How much?_____For how long?_____

## Review of Systems (circle all that apply)

**General**: usual weight ____ , recent weight loss, recent weight gain, weakness, fatigue, fever, chronic fatigue syndrome, fibromyalgia

**Skin:** rashes, lumps, itching, dryness, color change, changes in hair or nails

**Head:** headache, head injury, migraine headache

**Eyes:** vision, glasses or contact lenses, last eye examination _____ , pain, redness, excessive Tearing, double vision, glaucoma, cataracts

**Ears:** hearing, ringing in the ears, vertigo, earaches, infection, discharge

**Nose and sinuses:** frequent colds, nasal stuffiness, hay fever, nosebleeds, sinus trouble

**Mouth and throat:** change in the condition of teeth and gums,

bleeding gums, sore tongue, Hoarseness, frequent sore throats,

last dental examination_____

**Neck:** lumps in neck, "swollen glands", goiter, pain in the neck

**Breasts:** lumps, pain, nipple discharge, self-examination (circle): regularly, irregularly, never

**Respiratory:** cough, excessive sputum, bloody sputum, wheezing, asthma, bronchitis, emphysema, Pneumonia, tuberculosis, pleurisy, tuberculin test date_____, last chest x-ray date_____

**Cardiac**: heart trouble, high blood pressure, rheumatic fever, heart murmurs, shortness of breath, number of pillow used at night , edema; chest pain, palpitations; past electrocardiogram or other heart tests

**Gastrointestinal:** trouble swallowing, heartburn, appetite, nausea, vomiting, vomiting of blood, Indigestion, frequency of bowel movements, change in bowel habits, rectal bleeding, black tarry stools, constipation, abdominal pain, food intolerance, excessive belching or passing of gas, diarrhea, hemorrhoids; jaundice, liver or gall bladder trouble, hepatitis

**Urinary:** frequency of urination, blood urine, painful urination, urgency, hesitancy' how many times do you get up to urinate at night?_____ incontinence; urinary infections, stone

**Genito-reproductive:**

**Male:** discharge from or sore on penis, history of venereal disease, hernias, testicular pain or masses; sexual difficulties

**Female:** age when periods started _____; date of last period: _____ ; bleeding between periods or after intercourse, painful periods; menopausal symptoms, age at menopause _____ , Number of pregnancies_____ ,

**Musculoskeletal:** joint pains or stiffness, arthritis, gout, backache. Muscle pains or cramps. Fibromyalgia, reflex sympathetic dystrophy

**Peripheral vascular:** cramping in the legs when walking, cramps, varicose veins, blood clots

**Neurological:** fainting, blackouts, seizures, paralysis, local weakness, numbness, tingling, tremors, memory problems

**Psychiatric:** nervousness, tension, mood swings, depression, PTSD, bipolar, ADD drug dependence or addiction; alcohol dependence or addiction

**Endocrine:** thyroid trouble, heat or cold intolerance excessive sweating, diabetes, excessive thirst, excessive hunger, excessive urination

**Hematologic:** anemia, easy bruising or bleeding, blood clots, past transfusions and/or possible reactions to blood products

**Infectious diseases:** TB, hepatitis, HIV, AIDS, staph infections, MRSA

I have answered this form truthfully and to the best of my ability

Signature: _____

**ORTHOPAEDIC ASSOCIATES of KENTUCKIANA PLLC**

**DEMOGRAPHIC INFORMATION**

| | | | |
|---|---|---|---|
| Patient's Name (First, Middle, Last) | | | |
| Patient's Address | | | |
| City, State | | Zip | |
| Date of Birth | Age | Sex | Soc Sec # |
| Home Phone | Cell Phone | Work Phone | |
| Are You: Actively Employed ❑ Retired ❑ Disabled ❑ | | | |
| Employer | | | |
| Employer's Address (Street) | | | |
| City, State | | Zip | |
| Occupation (Indicate if Student) | | | |
| Nearest Relative/Friend (not in same household) | | | |
| Address | | Phone | |
| City, State | | Zip | |
| Referred by | | Phone | |
| Address | | | |
| City, State | | Zip | |
| Family Doctor or Pediatrician | | Phone | |
| Address | | | |
| City, State | | Zip | |
| Is Spouse Employed ❑ Retired ❑ Disabled❑ | | Soc. Sec. No. | |
| Employer | | Employer's Phone | |
| Occupation | | | |
| Employer Address (Street) | | | |
| City, State | | Zip | |

| | | | |
|---|---|---|---|
| Father's Name (First, Middle, Last) | | Soc Sec No | |
| Employer | | Employer's Phone | |
| Occupation | | | |
| Employer's Address (Street) | | | |
| City, State | | Zip | |
| Mother's Name (First, Middle, Last) | | Soc. Sec. No. | |
| Employer | | Employer's Phone | |
| Occupation | | | |
| Employer Address (Street) | | | |
| City, State | | Zip | |
| Name of Policyholder | | Birth date | |
| Insurance Address | | | |
| City, State | | Zip | |
| Policy Number | | Group Number | |
| SECONDARY INSURANCE | | | |
| Name of Policyholder | | Birth date | |
| Insurance Address | | | |
| City, State | | Zip | |
| Policy Number | | Group Number | |
| If Accident Related | Work Injury ❑ Yes ❑ No | Automobile Injury ❑ Yes O No | |
| Date of Accident and Description | | | |
| | | | |
| | | | |
| | | | |

RELEASE INFORMATION: I hereby authorize the release of medical information to my family doctor and/or referring doctor and to insurance carriers concerning my illness and treatment. I hereby request payment of benefits to Orthopaedic Associates of Kentuckiana, PLLC. I understand I am responsible for any amount not covered by insurance.

SIGNATURE PATIENT OR GUARDIAN _____ Date_____

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

# WORK COMP WORK SHEET

| | |
|---|---|
| Claimant Name | |
| Address | |
| Phone Number | Home Cell |
| Birth Date | |
| SS# | |
| Date of Injury | |

| | |
|---|---|
| Are X-rays approved | |
| Body Part? Right or Left | |
| Date of Injury | |
| Who Gets Report? | |
| Phone Number | |
| Fax Number | |

## Billing

| | |
|---|---|
| Claim Number | |
| Carrier | |
| Adjuster | |
| Email | |
| Address | |
| Phone number | |
| Fax number | |

## Case Manager

| | |
|---|---|
| Case Manager | |
| Email | |
| Fax Number | |
| Phone Numbers | |
| Notes to be sent by | Fax Email Snail mail |

FORM 106
ADOPTED JULY 2003

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
CLAIM NO:_____

# MEDICAL WAIVER AND CONSENT

I, _____ having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any health care provider to furnish to myself, my attorney, my employer, its workers' compensation carrier or its agent, the Division of Workers' Compensation Funds, the Uninsured Employers' Fund, or Administrative Law Judge any information or written material reasonably related to my work-related injury occurring on or about _____ any medical information relevant to the claim including past history of complaints of, or treatment of, a condition similar to that presented in this claim or other conditions related to the same body part.

Such information is being disclosed to the purpose of facilitating my claim for Kentucky workers' compensation benefits.

I understand I have the right to revoke this authorization in writing at any time, by sending written notification to each individual health care provider, but such revocation will not have any affect on actions taken prior to revocation. Moreover, inasmuch as KRS 342.020(8) requires a medical waiver to be executed, revocation may result in suspension or delay of the workers' compensation claim.

I understand that no medical provider may condition treatment or payment on whether I sign this medical waiver; however, I further understand that failure to sign this medical waiver may result in suspension or delay of the workers' compensation claim.

I understand that the information used or disclosed pursuant to this medical waiver may be subject to re-disclosure by the recipient.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

The authorization includes, but is not restricted to, a right to review and obtain all copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

Signed at _____, Kentucky, this _____ day of _____, 20_____.

_____
Signature of Patient Or Personal Representative

Social Security Number: _____

_____
Witness Signature

_____
Description Of Personal Representative's Authority

## KENTUCKY WORKERS' COMPENSATION AND HIPAA

On April 14, 2003, the federal Health Insurance Portability and Accountability Act [HIPAA] privacy regulation will take effect. This regulation limits the situations in which medical providers may release patient information, unless the information is necessary for the purpose of treatment, payment, or health care operations. Moreover, it is important to note that disclosures for workers' compensation are in most instances exempt from HIPAA privacy requirements. The exact wording is as follows: "A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation…"

Since HIPAA defers to state law regarding disclosures relating to workers' compensation, it is important for claimants and medical providers to know what Kentucky law requires for disclosure of patient information. An employee who reports a work injury or who files for workers compensation benefits must "execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation." KRS 342.020 (8). Kentucky law further states that once this Form 106 is signed, any health care provider "shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer [or its agent or assignee], special fund, uninsured employers' fund, or the administrative law judge, provide the **requesting party** with any information or written material reasonably related to any injury or disease for which the employee claims compensation."

Once the Form 106 is signed, health care providers may disclose information as set out in Kentucky law. Another section of the regulation allows release of information pursuant to an administrative or judicial order or subpoena, provided that there has been a reasonable effort to notify the injured worker [or his attorney] that such a request has been made. Should there be questions regarding disclosures pursuant to this form, appropriate legal counsel should be consulted or you can contact the Department of Workers' Claims at 1-800 554-8601.

**Form 113**
Designation of Physician
Revised 03-12-03

**Two-Sided Form**

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
Claim No. _____

## NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: _____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

_____ _____
Date of Birth Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

_____
Name

_____
Street Address

_____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: _____

_____

DATE OF INJURY OR LAST EXPOSURE: _____

FIRST DESIGNATED PHYSICIAN:

_____
Name

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

Accepted by: _____

**MEDICAL INFORMATION RELEASE:** I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

_____ _____
Date Employee Signature

MEDICAL PAYMENT OBLIGOR:

_____
Name Of Obligor

_____
Representative

_____
Street Address

_____ ( ) _____
City, State, Zip Telephone Number

**This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.**

Notice: The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effects of a workplace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

# Notice of Privacy Practices

***Effective 1/1/2013***

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 Orthopaedic Associates of Kentuckiana, PLLC., Privacy Officer at (502) 585-4376.

PURPOSE

Orthopaedic Associates of Kentuckiana, PLLC. (OA), its team members, medical staff, employed physicians, residents, fellows, students, contractors and volunteers follow the privacy practices described in this Notice of Privacy Practices (Notice). This Notice describes the ways in which we may use and disclose your health information within OA and with other entities. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information. OA participates in an Organized Health Care Arrangement (OHCA) with its Medical Staff and will share your health information with the arrangement's participants to carry out treatment, payment or health care operations related to the OHCA. OA facilities are committed to protecting your health information in a confidential manner.

WHO WILL FOLLOW THIS NOTICE?

OUR LEGAL RESPONSIBILITIES

OA is required by law to protect the privacy of your health information that can identify you, inform you about our legal duties and privacy practices with respect to your health information, and follow the terms of this Notice. This Notice applies to all of your health information held by OA.

- OA must abide by the terms of this Notice.
- OA must notify you if we are unable to agree to a restriction that you request about the use and disclosure of your protected health information.
- OA must accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

OA will not use or disclose your health information without your authorization, except as described in this Notice.

REVISIONS TO THIS NOTICE

OA may change its Notice at any time and make the new provisions effective for all health information OA maintains. Upon your request, OA will provide you with information about how to obtain a revised Notice of Privacy Practices by accessing our web site, *www.oadocs.com,* by calling the OA Privacy Officer at (502) 585-4376 to request a revised copy be mailed to you or by requesting one at the time of your next visit.

**HOW OA WILL** USE AND DISCLOSE YOUR HEALTH INFORMATION

*Treatment, Payment and Health Care Operations (TPO).* OA will use or disclose your health information for treatment, to obtain payment for treatment and for health care operations.

The examples below are not meant to be exhaustive, but describe common types of disclosures OA may make.

Examples of Uses and Disclosures for Treatment OA will use and disclose your health information to:

- Anyone involved in your treatment, including physicians, nurses, therapists, pharmacists, radiologists, discharge planners, dietitians, laboratory and others who need access to your health information to assist in your diagnosis and treatment.
- Anyone necessary to provide or manage your health care treatment, including the coordination or management of your care with a provider outside OA, such as a home health agency that is evaluating your need for home health services.
- The physician who referred you to OA or who will provide follow-up care to you after you are discharged from OA.

**Examples of Uses and Disclosures for Payment** OA will use and disclose your health information to:

- Obtain payment for the services and treatment you receive.
- Communicate with your health insurance plan to obtain approval for the health care services OA recommends for

you.

- Request a determination from your health insurance plan of your eligibility or coverage for insurance benefits.
- Obtain payment from your employer when your treatment involves a work-related injury
- Other health care providers so they can receive payment for health care services that they provided to you, such as ambulance services.
- Review the care you received to ensure the costs associated with it were appropriate for your diagnosis.

**Examples of Uses and Disclosures for Health Care Operations**

OA will use and disclose your health information to support OA business activities.
These activities include:

- Conducting quality assessment and improvement activities in an effort to continually improve the quality and effectiveness of the health care services we provide
- Developing clinical guidelines
- Evaluating clinical outcomes
- Reviewing the competence or qualifications of health care professionals
- Evaluating physician and employee performance
- Conducting training programs in which residents, students, trainees or practitioners in areas of health care learn under supervision to improve their skills as health care providers
- Participating in accreditation, certification, licensing or credentialing activities
- Conducting or arranging for medical review, legal services and auditing functions
- Sharing information with medical students and residents who see patients at a OA facility
- Calling your name in a waiting area or over the overhead paging system
- Contacting you by mail or phone to remind you of a scheduled appointment, procedure or test
- Providing information to the Chaplain who may visit you
- Planning for the organization's future operations Complying with this Notice and applicable laws.

**OTHER USES AND DISCLOSURES REQUIRED BY HIPAA**

OA may use and disclose your health information in the following situations without your authorization. These situations include:

*Business Associates of OA:* Some services are provided through contracts with business associates. Examples include certain laboratory tests and the service OA uses when making copies of your medical record. When these services are contracted, OA may disclose your health information to our business associates so that they can perform the job OA has asked them to do and bill you or your insurance carrier for services rendered. To protect your health information, however, OA requires the business associate to appropriately safeguard your information.

*Research:* OA may disclose your health information for medical research when the Institutional Review Board or Privacy Board approves the research study and the use of your health information.

*Marketing:* OA may use and disclose health information to contact you with information about treatment, services, products or health care providers that may be of interest to you.

*Funeral Directors, Coroners and Medical Examiners:* OA may disclose health information to a coroner, medical examiner or funeral directors consistent with applicable law to carry out their duties.

*Organ procurement organizations:* Consistent with applicable law, OA may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

*Food and Drug Administration (FDA):* OA may disclose health information to the FDA relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

*Public Health:* As required by law, OA may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. These activities include but are not limited to reporting births, deaths, disease, injury, child abuse or neglect and domestic violence.

*Inmates:* If you are an inmate of a correctional institution, or under the custody of a law enforcement official, OA may disclose your health information to the institution or law enforcement official as may be necessary for your health and the health and safety of

other individuals.

*Legal Proceedings:* If you are involved in a lawsuit or dispute, OA may disclose your health information in response to a HIPAA-compliant subpoena, valid court or administrative order, or discovery request. OA also may disclose your health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

*Law Enforcement:* OA may disclose health information as required by law or in response to a HIPAA-compliant subpoena, valid court or administrative order, warrant, summons, or other lawful process. We must provide information about someone who is suspected of being a victim abuse, neglect or domestic violence; to provide information about a crime that occurs at a OA facility or to identify or locate a suspect, fugitive, material witness or missing person.

*Health Oversight Activities:* OA may disclose your 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.

*Military Activity and National Security:* OA may release your health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law, including providing protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

**USES AND DISCLOSURES TO WHICH YOU MAY OBJECT**

Unless you notify us in writing that you object, OA may use or disclose your health information in the following circumstances:

- OA may disclose to a member of your family, a relative, a close friend or any other person you identify as your emergency contacts, your health information that relates to that person's involvement in your care or payment related to your care. OA may use or disclose your health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, about your location, general condition or death.
- OA may use and disclose your health information to a public or private entity (such as the American Red Cross) assisting in disaster relief efforts so that your family can be notified about your condition, status and location.
- OA may use and disclose your health information for the above activities when you are unable to agree or object to the use or disclosure because of your incapacity or an emergency treatment circumstance, if such disclosure is consistent with a prior expressed preference and if we determine such disclosure is in your best interest. When it becomes practical to do so, we must provide you with an opportunity to object to the uses or disclosures of your health information as described above.

To object to these uses or disclosures, please contact the OA Privacy Officer at (502) 585-4376.

**USES AND DISCLOSURES YOU MUST AUTHORIZE**

Except as described above, OA will not use or disclose your protected health information unless you give written authorization to OA to do so. You may revoke your permission, which will be effective only after the date of your written authorization was received. If you revoke your authorization in writing, OA will not disclose health information about you after OA receives your revocation except for disclosures that were being processed prior to receipt of your request.

**YOUR INDIVIDUAL RIGHTS**

Below is a statement of your rights with respect to your health information and a brief description of how you may exercise these rights. For more information about your rights, please contact the OA Privacy Officer at (502) 585-4376.

Right of Access. You have the right to access, inspect and obtain a copy of your health information that is contained in a designated record set for as long as we maintain the health information. A "designated record set" contains medical and billing records and any other records that are used by OA or its Medical Staff to make decisions about you. Your request must be in writing. OA must act on your request no later than 30 days after receipt of the request. If the protected health information is not maintained or accessible on-site, OA must take action no later than 60 days from receipt of your request. OA also may extend the time for such actions by no more than 30 days. OA must provide you with a written statement of the reasons for the delay and the date by which it will complete your request. In Kentucky, you may receive one free copy of your medical record. Additional copies are made at a rate of $1 per page. Under federal law, however, you may not access, inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding and health information that is subject to law that prohibits access to health information. OA may deny your request to inspect and copy in certain circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by OA will review your request and the denial. The person conducting the review will not be the person who denied your request. OA will comply with the outcome of the review.

**Right to request restrictions.** You have the right to request restrictions on certain uses or disclosures of your health information for the purposes of treatment, payment or health care operations. You also may request limits on the health information OA discloses about you to family members, friends or other individuals identified by you who may be involved in your care or for

notification purposes as described in this Notice. OA is not required to agree to your request. If OA agrees, OA will comply with the requested restriction unless it is needed to provide emergency treatment. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

**Confidential Communications.** You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at an alternative location from your home address, such as work, or only contact you by mail instead of by phone. Your request must be in writing. OA will accommodate reasonable requests. OA also may 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. OA will not request an explanation from you as to the basis for the request.

**Right to Amend.** If you believe the health information OA has about you is incorrect or incomplete, you may request the information be amended. You have the right to request an amendment for as long as the information is kept by or for the OA facility that maintains the record. Your request must be in writing and must explain the reason for the requested amendment. OA must act on your request for an amendment no later than 60 days after receipt of such a request. In certain cases, OA may deny your request for an amendment. If OA denies your request for amendment, you have the right to file a statement of disagreement with OA and OA may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures OA made of your health information for purposes other than treatment, payment or health care operations as described in this Notice. It excludes disclosures OA may have made to you, requested by you or that you authorized, as well as for a facility directory, to family members or friends involved in your care, or for notification purposes. Your request must be in writing. OA must act on your request for accounting no later than 60 days after receipt of such a request. You have the right to receive specific information regarding these disclosures made up (6) years before your request (not including disclosures made before April 14, *2003).* You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request a list of disclosures more than once in *12* months, OA may charge you a reasonable fee.

**Right to a Copy of this Notice.** On your first visit to a OA facility, you will be given a copy of this Notice. You also may request a summary of this Notice. You may obtain a copy of this Notice at the OA web site, *www.OAdocs.com. To* obtain a paper copy of this Notice, visit the OA facility where you are receiving services.

**IF YOU HAVE A PROBLEM**

If you believe your privacy rights have been violated, you may file a complaint with the OA Privacy Officer, with the Secretary of the U.S. Department of Health and Human Services or with the U.S. Department of Health and Human Services Office of Civil Rights. OA will not retaliate against you for filing a complaint. To file a complaint, contact the Privacy Officer at *(502) 585-4376*or send correspondence to:

*Privacy Officer*
*Orthopaedic Associates of Kentuckiana, PLLC*
*3605 Northgate Court*
*Suite 202*
*New Albany, IN 47150*

*Revised December 2012*

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

# NOTICE OF PRIVACY PRACTICES RECEIPT

THE ATTACHED 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.

The attached document is our Notice of Privacy Practices. You may review it now or later. At some point, you should read the Notice carefully because it explains:

1. Generally how we use health care information about you.

2. That we may use and disclose your health information to provide treatment, to obtain payment for our services, and for our internal operations. We are not required to have your separate permission for these purposes.

3. Other circumstances where we may use or disclose information about your health without asking for your permission.

4. Your rights you have about your health information that we keep, including your rights to:

* Have a copy of our Notice of Privacy Practices.

* Review and copy your health information that we keep.

* A list of how we give out your health information for certain purposes.

*Ask that we use a special address or telephone number to contact you.

* Ask for limits on how we use your health information for certain purposes.

* Ask for an amendment to your record if you think it is not correct.

* File a complaint if you think your privacy rights have been violated.

**Acknowledgement of Receipt**: Orthopaedic Associates of Kentuckiana, PLLC provided me a copy of its Notice of Privacy Practices

_____ _____ _____

Printed Name Signature Date

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

# INFORMATION RELEASE CONSENT

Patient Name:_____

(Please print full name)

In the case that I need Orthopaedic Associates, PSC to speak to someone other than myself regarding my-medical care or my account information, I authorize the following person(s) to do so:

(Name)_____ (Relationship to patient) _____

(Name)_____ (Relationship to patient) _____

(Name)_____ (Relationship to patient) _____

I understand that **in the case that I do not want** any such person to have the authorization to talk to Orthopaedic Associates, PSC regarding my medical care or my account information, it is my sole responsibility to inform Orthopaedic Associates, PSC in writing of this immediately. We will use reasonable efforts to identify the person(s) designated providing that we bear no responsibility for disclosures for individuals who misrepresent themselves.

_____ _____

(Signature) (Date)

# ORTHOPAEDIC ASSOCIATES of KENTUCKIANA, PLLC

## HIPAA AUTHORIZATION FORM

I, _____, hereby authorize ORTHOPAEDIC ASSOCIATES of KENTUCKIANA to use and/or
Name of Patient
disclose my protected health information described below to _____.
Name of Person or Entity to receive the information

My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose]: _____
_____
_____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

- ❑ Any and all records in the possession of ORTHOPAEDIC ASSOCIATES of KENTUCKIANA including mental health, HIV, and/or substance abuse records
  [Cross out any item you do not authorize to be released]
- ❑ Records regarding treatment for the following condition or injury _____ on or about _____.
- ❑ Records covering the period of time _____ to _____.
- ❑ Other [please specify - include dates]_____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to
__OFFICE MANAGER, ORTHOPAEDIC ASSOCIATES of KENTUCKIANA, PLLC, 3605 NORTHGATE COURT, SUITE 102, NEW ALBANY, INDIANA 47150
I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that ORTHOPAEDIC ASSOCIATES of KENTUCKIANA may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] _____.

I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

*The source of this document is the Kentucky Medical Association.

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

# HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I HEREBY REQUEST A RELEASE OF THE FOLLOWING PATIENT'S MEDICAL RECORD.

Full Name of Patient:_____

Patient Address:_____City/State_____ Zip Code_____

Patient's Date of Birth:_____SSN(optional)_____

I AUTHORIZE INFORMATION TO BE RELEASED FROM (RELEASOR)

Address:

This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.
Description of records to be released_____
Date of service or date ranges requested_____

THE ABOVE INFORMATION IS TO BE RELEASED TO:
Name & Title:_____
Street Address:_____
City/State/Zip:_____ Phone Number:_____

THE ABOVE INFORMATION IS REQUESTED TO BE RELEASED FOR THE FOLLOWING PURPOSE: ❑ Continued medical care ❑ Other
This authorization must be signed and dated, and may be revoked at any time except to the extent that information has already been used or disclosed in reliance on the Authorization. Revocation must be made in writing to the Releasor of the information. This authorization will expire on_____ . I hereby acknowledge that I understand treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing of this Authorization. Once these records are released, the information is not protected under HIPAA, and may potentially be re-disclosed by the party who received these records. I hereby state that I have read and fully understand the above statements as they apply to me.

Patient Signature_____ Date _____
Parent, Guardian, or
Authorized Representative_____

Relationship to Patient on Chart _____

Witness_____