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 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 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.
6. If you have a lawyer, please include him as a person who can receive your medical information.

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?

Are you using any other medicines? Please include over the counter or natural meds

Medicine Name	Dosage	How Often	When did you start?

Is there anything else the doctor should know?

I have answered the questions truthfully and as best I can

Signature:_____ Date:_____

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PATIENT MEDICATIONS and ALLERGIES

Name_____ Date of Birth_____

Today's Date_____

ALLERGIES

Medication	Reaction (What goes wrong when you use the medicine?)

CURRENT MEDICATIONS

Medication	Dosage	How Often?	For What Condition?

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?

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

TO:_____

_____

_____

I have asked Orthopaedic Associates of Kentuckiana, PLLC to provide medical care to me for injuries sustained involving a liability claim on_____. My request, and the practice's acceptance of me as a patient, was based on the understanding that I would assign any benefits payable by your company as a result of that liability related injury in order to pay the related medical expenses that I have incurred or will incur with the practice.

This letter serves as notice that I hereby irrevocably assign to Orthopaedic Associates of Kentuckiana, PLLC any benefits payable by your company in respect to the liability related injury referenced above. This assignment is made for the amount of my related medical expenses now or hereafter incurred with the practice and includes, without limitation, my basic and any added reparation benefits.

I acknowledge that the insurance coverage has limits on the total amount that might be paid, and my allocation of benefits to my medical expenses may draw down or exhaust the benefits that might otherwise be available for any other element of loss that might be payable under your policy(ies). I nevertheless direct that payment of benefits for medical expenses in this liability related injury first be paid directly to Orthopaedic Associates of Kentuckiana, PLLC in accordance with this assignment and notice.

_____ _____
Signature Date:

_____ _____
Printed Patient Name Witness

_____ _____
Other Responsible Person Relationship to Patient

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

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

FEE AGREEMENT

When used in this Agreement, the terms "you" and "your" refer to Orthopaedic Associates of Kentuckiana, PLLC The terms "I", "me" and "my" refer to the Patient or Other Responsible Person whose signature appears at the bottom of this document.

If I am signing in my capacity as the Patient's Responsible Party, I represent to you that I have full power and authority to make the following acknowledgements and agreements on behalf of the Patient as well.

I have asked you to provide medical care to the Patient named above. In so doing, I acknowledge that you may have a discounted fee arrangement with my health care benefits plan. I also acknowledge that any discounts you may have given extend only to contracted health care benefits plans. They do not extend to third persons such as other health care benefit plans with which you do not have a contract, workers' compensation plans, automobile and other liability insurance companies and potential defendants against whom I may have a claim for damages related to my medical condition.

Even if you have a contract with my health benefits plan, I acknowledge and agree that you will be entitled to payment at your full and customary fee schedule if my health care benefits plan is not ultimately responsible for paying for your medical services. For example, your full and customary fee schedule will apply when the nature or cause of my medical condition creates a coverage exclusion and when my health care benefits plan is entitled to be repaid because liability is imposed on or accepted by a third party.

Initial if the following paragraph applies: Patient/Responsible Party:____

Orthopaedic Associates
Representative: _____

I am asserting, or plan to assert, against third persons claims for damages related to the medical condition for which I have requested your services. At my request, you have agreed to postpone collecting your fees. In return, I hereby agree to give you periodic progress reports on my claims as you may request. I also grant you a lien on any payments that may be made to or for my benefit in respect to the injury or injuries that contributed to my medical condition. As noted above, the lien is for the amount determined by your full, non-discounted fee schedule. I further agree that, as you may request, I will give written notice to my attorney and to potentially responsible parties that I have granted this lien. I also acknowledge and agree that you may proceed with collection at any time by sending me written notice of your intent at the last address you have for me. In that event, the lien will be deemed to be release when the notice letter is deposited in the U.S. mail.

_____	_____
Print Name	Signature
_____	_____
Date	Witness
_____	_____
Other Responsible Person	Relationship to Patient

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

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

To: Attorney_____

_____

_____

Re: Patient:_____SS#:_____

I hereby authorize and direct you, my attorney, to pay directly to Orthopaedic Associates of Kentuckiana, PLLC such sums as they may be due and owing them for professional services rendered me both by reason of _____and by reason of any other bills that are due them and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said organization. I hereby further given a lien on my case to said organization against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said organization for all professional bills submitted by them for services rendered me and that this agreement is made solely for said organization's additional protection in consideration of it awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fees. I also understand that Orthopaedic Associates' agreement to defer collection of its fees is an accommodation to me, and it may initiate collection activities at anytime by giving me or my attorney written notice of its intent to do so. Further, any limitation or the time to initiate a collection action shall be suspended from the date of my signature below until my account is paid in full or Orthopaedic Associates gives notice of its intent to initiate collection activities.

Dated: _____ Patient's Signature: _____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Orthopaedic Associates of Kentuckiana, PLLC I also agree to supply said organization with information necessary to file commercial insurance on behalf of the patient, if I have such information, and to said provide said organization with a written update of the status of settlement, judgment or verdict at least every sixty (60) days. Failure to provide status reports to organization is a material breach of this agreement.

Dated: _____ Attorney's Signature _____

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

Patient Responsibilities and Collection Policies

We welcome you and are grateful that you have chosen us to be your physician, For your information and convenience, we want to make you aware of our billing policies, which are largely dictated by Medicare, other rules and regulations and your health plan's requirements. Please note that we charge a $50 fee for missed appointments if we are not notified 24 hours in advance.

PATIENT RESPONSIBILITIES

It is your responsibility to give our office current and up to date information, This includes your name, changes to your address and telephone number, changes in your health status and information about other health services that you may have received, and your current insurance information.

It is your responsibility to provide our office with any needed referrals from your primary care physician. It is your responsibility to know your health plan's policies and guidelines. Every health plan is different. It is also your responsibility to contact your health plan to verify that any physician you see in this practice is a participating physician with your health plan.

COLLECTION POLICIES

We will collect your co-payment at the time of your visit. Your health plan and the laws that relate to billing practices require these payments in most instances. We will then file a claim with your health plan for you, We prepare claims based on the information provided by you as the reason for your visit and the diagnoses and/or procedures performed by the physician, In compliance with legal and ethical rules, we submit claims based on actual services provided, not based on what your health plan covers.

You are responsible for the balance remaining after your health plan pays its portion. You will receive a monthly statement from us. If you fail to pay your bill in full or fail to make payment arrangements with US within 60 days after the date of your first statement, your account will be placed in our collection department. If we do not hear from you, your account will be sent to an outside collection agency, which could adversely affect your credit. For your convenience, we accept Debit Cards, Master Card, Visa, and American Express.

I understand my responsibilities and agree to be responsible to see that my account is kept current.

_____	_____	_____
Patient or Guarantor Signature	*Date*	*Witness*