NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Introduction

At Southern Orthopaedic Specialists, P.C. we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal Information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time your visit the facility, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A Basis for planning your care and treatment
- A Means of communication among the many health professionals who contribute to your care
- A Legal document describing the care you received
- A Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your medical record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Southern Orthopaedic Specialists, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.524
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164,522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Southern Orthopaedic Specialists, P.C. is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will have the information available for you to request at our office. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use and/or disclosure of your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the facility's Privacy Officer at:

Southern Orthopaedic Specialists, P.C.
516 Brookwood Boulevard
Birmingham, AL 35209
(205) 397-2663

If you believe your privacy rights have been violated, you can file a complaint with the facility's Privacy Officer or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retaliation for the filing of a complaint with either the Privacy Officer or the Office for Civil Rights.

The address for OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

- You may also file a complaint online at **www.hhs.gov**

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

We will use your health information for payment.

For Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication With Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we 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.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Southern Orthopaedic Specialists, P.C.
516 Brookwood Boulevard
Birmingham, AL 35209
(205) 397-2663

Last Edited:
January 2017

SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

Dr. Gregg K. Carr, M.D.
516 Brookwood Blvd
Birmingham, AL 35209
P: 205-397-2663
F: 205-278-0049

Patient Information and Profile

Name: _____DOB: _____ Age: ___ Race: ___ Preferred Language: _____

Marital Status: ___Single ___Married ___Widowed ___Divorced **Ethnicity**: ___Hispanic ___Not Hispanic

Females Only: Are you pregnant? ___Yes ___No *If "No", Date of last menstrual period:* ____/____/____

Do you have a Primary Physician? ___Yes ___No *If "Yes", what is his/her name?* _____

Who referred you to our office? (Doctor, Patient, or a Friend) _____

Reason for today's visit: _____

Is your problem due to an accident? ___Yes ___No *If "Yes", what is the date of injury?* ____/____/____

Where did your injury occur? _____ How did your injury occur? _____

_____

Do you have drug allergies? ___Yes ___No If "Yes", please list drug and reaction: _____

_____

Are you allergic to Betadine, Adhesive Tape, Xylocaine, or Latex? (If yes, please circle those that apply)

Have you ever experienced any complications with anesthesia? ___Yes ___No

If "Yes", please explain: _____

Are you currently taking blood thinners (Coumadin, Plavix, Aspirin, etc.)?_____

List <u>all</u> medications that you are currently taking. Please also include **<u>all</u>** over the counter medications:
(If you have a separate list of medications, attach it to this form and write "see list" below)

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Your pharmacy's name, phone number, and zip code: _____

Please list previous surgeries and approximate dates of these procedures:

1. _____ Date: _____/_____/_____

2. _____ Date: _____/_____/_____

3. _____ Date: _____/_____/_____

4. _____ Date: _____/_____/_____

5. _____ Date: _____/_____/_____

List any medical conditions affecting your immediate family (blood relatives only):

1. _____ Relation: _____

2. _____ Relation: _____

3. _____ Relation: _____

4. _____ Relation: _____

Do you currently smoke tobacco? ___Yes ___No **Do you use smokeless tobacco?** ___Yes ___No

How long? ____ Years, ____ Months *How many packs do you/did you smoke per day?* _____ Packs/day

Do you currently consume alcoholic products? Yes: ____ No: ____

If "Yes", how many drinks per day? I consume about _____ Drinks/day on average

GENERAL MEDICAL HISTORY

GENERAL

___Bleeding
___Blood Clots
___Cancer
___Diabetes
___Fever or Chills
___Fibromyalgia
___Frequent Dizziness
___Glasses or Contacts
___Itching or Rash
___Lumps or Masses
___Night Sweats
___Severe Childhood Illness
___Sleep Disorder
___Thyroid Problems
___Urinary Frequency
___Weight Change

GASTROINTESTINAL

___Acid Reflux
___GI Ulcers or Bleeding
___Jaundice/Hepatitis
___Nausea or Vomiting

CARDIOVASCULAR

___Heart Attack
___Heart or Chest Pain
___Heart Disease
___High Blood Pressure
___Mitral Valve Prolapse
___Atrial Fibrillation
___Heart Bypass

RESPIRATORY

___Asthma
___Chronic Bronchitis
___Cough/Sputum
___Emphysema/COPD
___Pleurisy/Pneumonia
___Rheumatic Fever
___Shortness of Breath
___Tuberculosis
___Sleep Apnea

NEUROLOGIC

___Numbness
___Paralysis
___Seizures
___Stroke
___Weakness
___Headaches

EYE-EAR-NOSE-THROAT

___Bleeding Gums
___Glaucoma
___Ringing in Ears
___Visual Change

MUSCULOSKELETAL

___Backache
___Gout
___Joint Pain
___Joint Swelling
___Lupus
___Sciatica

GENITOURINARY

___Incontinence
___Kidney Failure
___Urinary Tract Infection
___Venereal Disease

****Do you currently have a pacemaker?** ___Yes ___No

Email Address: _____

Signature of Patient: _____ **Today's Date:** _____/_____/_____

PATIENT REGISTRATION FORM – PLEASE PRINT

Date of Visit

SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

Primary Care Physician and Phone Number:

PATIENT INFORMATION

Last Name	Suffix (Jr, etc.)	First Name	M.I.	Age

Street Address	Zip Code	City	State

Soc. Sec. No.	Home Phone	Work Phone	Cell Phone	Sex		Marital Status				D.O.B.
				M	F	S	M	W	D	

Patient's Employer	Work Address	Employer's Phone

RESPONSIBLE PARTY INFORMATION

Relationship to Patient	Name	Social Security No.	Driver's License No.

Street Address	Zip Code	City	State

Home Phone	Work Phone	Cell Phone	Name of Employer

Employer's Street Address	Zip Code	City	State

INSURANCE INFORMATION

PRIMARY INSURANCE			SECONDARY INSURANCE		
Name of Insurance Company			Name of Insurance Company		
Policy No.	Group No.	Effective Date	Policy No.	Group No.	Effective Date
Relationship to Patient	Name of Insured		Relationship to Patient	Name of Insured	
Date of Birth	Insured's Employer	Copay $	Date of Birth	Insured's Employer	Copay $

INJURY INFORMATION

Job Related? ☐ Yes ☐ No	Date of Injury	Date Last Worked	Employer at Time of Injury

Workmans' Compensation Carrier	Where were you injured?
How did your injury occur?	Employer rep. who authorized treatment

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

Person to contact	Relationship	Phone Number

Street Address	City	State	Zip

AUTHORIZATION AND RELEASE

I hereby authorize SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C. (SOS) to release for insurance purposes any information acquired in the course of my examination or treatment. I authorize payment from my insurance company to be made directly to SOS for any treatment I receive while under their care. I will be responsible for any charges not paid by my insurance company.

I understand that I am responsible for payment of my account, and I agree to pay all costs of collection and interest charges, including a reasonable attorney's fee.

_____ _____

Patient's/Responsible Party's Signature Date

SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C.

Dr. Gregg K. Carr, M.D.
516 Brookwood Blvd
Birmingham, AL 35209
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F: 205-278-0049

HIPAA AUTHORIZATION FORM

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____ **SSN:** _____

_____ **Email:** _____

I authorize Southern Orthopaedic Specialists, P.C. to discuss my medical information with the following people:

☐ None ☐ Parents: _____

☐ Spouse: _____ ☐ Mother (only): _____

☐ Guardian: _____ ☐ Father (only): _____

☐ Other: _____ relationship to patient: _____

I authorize Southern Orthopaedic Specialists, P.C. to contact me in the following manner(s) (check all that apply):

Home Telephone _____
☐ Okay to leave a message with detailed information
☐ Leave message with call back number only

Work Telephone _____
☐ Okay to leave a message with detailed information
☐ Leave message with call back number only

Written Communication
☐ Okay to mail to my home address
☐ Okay to mail to my work address
☐ Okay to fax to this number: _____

Email: _____

The HIPAA Privacy Act generally requires healthcare providers to take responsible steps to limit the disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record. Uses and disclosures of protected health information may be permitted without prior consent in an emergency.

You agree, in order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ACKNOWLEDGEMENTS:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Southern Orthopaedic Specialists, P.C.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Personal Representative's relationship to the Patient Signature of Witness

_____
PRINT Personal Representative's Name

Southern Orthopaedic Specialists, P.C.

Consent Disclosures

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any and all collections agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Southern Orthopaedic Specialists and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending you text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

NON-COVERED ROUTINE SERVICES POLICY: As your physician, I want to provide you with the best care possible. There may be certain routine services that I feel are necessary for the maintenance of good health that are not covered by your insurance contract, for example, I may order orthopaedic supplies (aircast, braces, heel cups, Ted hose, etc.). Let me assure you that I will order only those items that I feel are necessary for your treatment and care.
If you have any questions regarding any of our policies please speak to someone in the office and we will be happy to assist you.

_____ _____

Patient/Responsible Party Date