



**Registration Form**

**Patient's Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Primary Contact Number:  Cell  Home  Work

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

Email address: \_\_\_\_\_

**Emergency Contact**

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

Primary Contact Number: \_\_\_\_\_  Cell  Home  Work

Alternate Contact Number: \_\_\_\_\_  Cell  Home  Work

**Contact Preferences**

<p>I wish to be contacted in the following manner: (check all that apply)</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Email</p>	<p>OK To leave a message with Detailed information?</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Email</p> <p>(see email request form)</p>	<p>Leave message with call back number only</p> <p><input type="checkbox"/> Cell</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Work</p> <p><input type="checkbox"/> Email</p>
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**Automated Appointment Reminders**

Precision Orthopedics has adopted an outside appointment reminder system of which will send you appointment confirmation requests via email 5 days prior, preferred phone two days prior, and a text one day prior to your appointment with limited information for the purpose of notifying you of your appointment time and the provider to which you will be seeing. I authorize my healthcare provider to disclose to this third party service limited Protected Health Information regarding my upcoming appointments. I consent to receiving these messages via email, phone and and/or text (text message rates will apply).

**Disclosure of Medical Information**

I hereby give permission to Precision Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

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

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

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

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions

**Notice of Privacy Practices**

\_\_\_\_\_ I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.  
(Initials)

**Facsimile Authorization for Coordination of Care**

I, the undersigned, authorize POSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary **coordination of care** for the patient listed below. **Medical records requests require separate form and authorization from this Facsimile Authorization.** I may revoke this authorization by giving POSM five (5) days written notice. This revocation may be by facsimile transmission; however, a **written copy of the revocation must be mailed to POSM as well.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Health History Form - Part 1 of 2**  
 (Please acknowledge each section; simply put "N/A" if it does not apply)

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Past Medical History**

- Acid Reflux
- A.D.H.D./A.D.D.
- Alzheimer's Disease
- Anemia
- Asthma
- Bipolar Disorder
- Bleeding Disorder
- Blood Clots
- Cancer \_\_\_\_\_
- Cholesterol
- Concussion

***Denies any Past Medical History***

- Congestive Heart Failure
- Crohn's Disease
- Diabetes – Type \_\_\_\_\_
- Digestive Problems
- Emphysema
- Gout
- Grave's Disease
- Heart Attack
- Heart Problems
- Hepatitis
- Herpes Zoster
- High Blood Pressure
- HIV or AIDS
- I.B.S.
- Kidney Problems
- Leukemia
- Liver Problems
- Lung Problems
- Lupus
- Mental Illness
- Morbid Obesity
- Neoplasm, Malignant
- Neoplasm, Benign
- Other \_\_\_\_\_
- Pneumonia
- Schizophrenia
- Seizures
- Sleep Apnea
- Stomach Ulcer
- Stroke
- Thyroid Disorder
- Tuberculosis

**Past Orthopedic Medical History**

- Bursitis
- Carpal Tunnel Syndrome
- Cerebral Palsy
- Contusion
- Dislocation \_\_\_\_\_
- Fibromyalgia
- Fracture \_\_\_\_\_

***Denies any Past Orthopedic Medical History***

- Ganglion
- Herniated Disc
- Multiple Sclerosis
- Osteoarthritis
- Osteopenia
- Osteoporosis
- Pain – Ankle / Foot
- Pain – Arm / Wrist
- Pain – Back
- Pain – Elbow
- Pain – Hand
- Pain – Hip
- Pain – Knee
- Pain – Leg
- Pain – Neck
- Pain – Shoulder
- Rheumatoid Arthritis
- Scoliosis
- Sprain / Strain \_\_\_\_\_
- Swelling of Joint

**Previous Surgical History:**

- Ankle Surgery
- Arm Surgery
- Back Surgery
- Breast Surgery
- Colon Surgery
- Ear/Nose/Throat Surgery
- Elbow Surgery

***Denies any Past Surgeries***

- Foot Surgery
- Hand Surgery
- Head Surgery
- Heart Surgery
- Hip Surgery
- Knee Surgery
- Leg Surgery
- Lung Surgery
- Neck Surgery
- Neuro Surgery
- Other \_\_\_\_\_
- Reproductive Surgery
- Shoulder Surgery
- Skin Surgery
- Stomach Surgery
- Thyroid Surgery
- Urology Surgery
- Vascular Surgery
- Wrist Surgery

**Family History**

- Alcoholism
- Anemia
- Arthritis
- Asthma
- Blood Disorders

***Denies any Family Medical History***

- Cancer \_\_\_\_\_
- Diabetes
- Gout
- Heart Problems
- Hypertension
- Kidney Problems
- Leukemia
- Mental Illness
- Musculoskeletal Diseases
- Other \_\_\_\_\_
- Respiratory Conditions
- Seizures
- Stroke
- Thyroid

**List all medications you are taking including vitamins or herbal supplements:**     **None**     **See Attached Listing**

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**List all known drug allergies:** \_\_\_\_\_

**Marital Status:**    Common Law Marriage    Divorced    Domestic Partner    Married    Separated    Single    Widowed

**Work Status:**    Disabled    Homemaker    On Leave    Retired    Student    Unemployed    Working: Full Time / Part Time

**How Did You Hear About Us:**

- Baylor ER
- Family/Friend
- Health Fair Expo
- Insurance Carrier Recommended
- Internet Search Engine
- POSM Website
- Magazine
- Newspaper
- Other \_\_\_\_\_
- Physician Referral
- Saw the Building
- Telephone
- ZocDoc website

**Patient Health History Form - Part 2 of 2**  
(Please acknowledge each section; simply put "N/A" if it does not apply)

**Primary Care Physician (full name):** \_\_\_\_\_ **Do you want a report sent to your PCP?**  yes  no

**Who referred you to us (full name)?** \_\_\_\_\_

**Pharmacy:** Name \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_

**Are you Pregnant?**  yes  no

**Work related?**  yes  no     **Sports related?**  yes  no     **Motor Vehicle Accident related?**  yes  no

**Do you drink alcohol?**  No Alcohol      Yes, consumes alcohol (\_\_\_ per day)      Social Drinker      Previous Alcoholism

**Do you use tobacco?**  Never      Currently (everyday)      Currently (some days)      Formerly

**Drug overuse/abuse:**  Never      Currently      In the Past

**Chief Complaint:** What is the main reason for your visit today? Describe problem in detail. (What Hurts)

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**Side:**  Left  Right  Both

**How long have you had pain?**  Weeks \_\_\_\_\_  Months \_\_\_\_\_  Years \_\_\_\_\_     **Date of Injury:** \_\_\_\_\_

**What is your pain quality?**  Dull  Sharp  Achy  Burning

**Where is your pain?**  Anterior (Front)  Posterior (back)  Lateral (Outside)  Medial (inside)

**When is pain the worst?**  Morning  Evening  After Strenuous Activity  At Night (interferes with sleep)

**Pain Level:**  1  2  3  4  5  6  7  8  9  10

**What actions/activities make the problem worse?**  Walking  Standing  Running  Bending  Lifting  Reaching  
 Overhead Activity  Driving  Sitting  Other: \_\_\_\_\_

**What actions/activities make the problem better?**  Resting  Ice  Heat  Elevation  Pain Meds  Activity  
 Other \_\_\_\_\_

**Are there any other associated signs or symptoms?**  Weakness  Numbness/Tingling  Radiating Pain  Instability

**Have you had any diagnostic studies or treatments for this problem? If so, when and where?**

X-ray  MRI  EMG  CT  Ultrasound

Physical Therapy (circle type: heat, ice, massage, chiropractic manipulation, ultrasound, traction, exercise)

Injections  Bracing  Surgery: \_\_\_\_\_

Other \_\_\_\_\_

Are there any specific treatment options that brought you to us? (i.e. Stem Cell, Visco-supplementation, PT/OT, etc)

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**By signing below I am verifying that the information provided above is complete and accurate.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient History Questionnaire  
REVIEW OF SYSTEMS**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please check any symptoms that you are currently experiencing.

Denies any current review of system symptoms

**Constitutional:**

- Chills
- Fever
- Headache
- Weight Gain
- Weight Loss
- Fatigue
- Body Aches
- Night Sweats

**Gastrointestinal:**

- Abdominal Pain
- Constipation
- Jaundice
- Diarrhea
- Nausea/Vomiting
- Ulcers

**Musculoskeletal:**

- Back Pain
- Joint Swelling
- Joint Pain
- Neck Pain
- Ankle Instability
- Limitation of Motion
- Muscle Cramps
- Muscle Pain

**Eyes:**

- Blurred Vision
- Double Vision

**Genitourinary:**

- Urine Hesitancy
- Incontinence
- Urinary retention
- Hematuria

**Endocrine:**

- Excessive Thirst
- Tired
- Too Cold/Hot

**HENT:**

- Sore Throat
- Difficulty Swallowing
- Ear Infection
- Nasal Congestion
- Nose Bleeding
- Headaches
- Sinus Pain

**Integumentary:**

- Boils
- Itching
- Redness
- Skin Rash

**Psychiatric:**

- Depression
- Difficulty Sleeping
- Anxiety

**Cardiovascular:**

- Chest Pain
- Heart Murmur
- Hypertension
- Palpitations
- Varicosities
- Rapid Heart Rate
- Irregular Heart Beat

**Neurologic:**

- Blackouts
- Dizziness
- Tingling/Numbness
- Seizures
- Tremors
- Sciatica
- Muscular Weakness

**Hema-Lymph:**

- Anemia
- Blood Clotting
- Swollen glands
- Easy Bruising

**Allergic/Immunologic:**

- Drug Allergies
- Hay Fever

**Respiratory:**

- Shortness of Breath
- Wheezing
- Cough

**By signing below I am verifying that the information provided above is complete and accurate.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Patient Consent for Treatment

I, knowing that I have a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care to such diagnostic, medical, and/or office based surgical treatment under the general and specific instruction of POSM's physicians and/or any other licensed healthcare service provider, assistants and/or designee as is necessary in their judgment. I also acknowledge that no guarantees have been made to me as to the results of the treatments or examination and that the possible risks, benefits, and complications of the said procedure have been discussed with me by the service provider.

#### Prescription Refill Policy

Prescriptions will only be written and refilled from Monday through Friday 8:00 am to 4:30 PM. **No prescriptions will be written or called in after these hours or on holidays and weekends.** Therefore, it is your responsibility to closely monitor your supply of medications. We recommend that you make your prescription requests at least 48 hours prior to running out of your prescriptions.

#### Financial Disclosure Notice to Beneficiary

This is a notice informing you that some and/or all physicians of Precision Orthopedics & Sports Medicine could have an ownership interest in these entities. Your physician's ownership interest means that your physicians may benefit from choosing to perform surgical procedures at one of the following facilities: Baylor Las Colinas, Methodist Southlake, Blue Star Surgery Center, and Pine Creek Medical Center. Because of this, your physician hereby advises you that you have the right to choose to be treated at a different facility, should you desire, and he will make such arrangements, if possible. These facilities are separate legal entities from Precision Orthopedics and Sports Medicine. You will receive a separate billing from each entity.

#### Financial Agreement

We are dedicated to providing the best possible care to you and regard your understanding of our financial policies an essential element of your care and treatment. This financial policy is intended to clarify these issues.

- Please present your insurance card and photo ID at each appointment. You must provide your most current billing address, all available telephone numbers, email address and any important contact information. If this information changes, it is your responsibility to contact us with your updated information. Your insurance policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, including obtaining the necessary referral authorizations, they may not pay for all or part of your care, and you may not qualify for any managed care discounts. If your insurance company does not pay within 60 days of the date of service, you may be expected to pay for the balance in full.
- Self-pay patients: There is a minimum deposit of **\$350.00** for New Patients and **\$200.00** for follow-up patients due upfront for all private pay patients for professional services to include office visit, X-ray, and injections if indicated; durable medical equipment and/or special services will be billed separately. All deposits must be cash or credit card only – no checks accepted. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency. Payment is due at the time the service is rendered unless other arrangements have been made in advance. We accept cash, checks, VISA, MasterCard, Discover and AMEX.
- Some durable medical equipment and/or supplies may not be covered by your insurance requiring payment at time of service.
- We charge for certain forms such as Disability and FMLA forms, as well as medical records.
- Responsibilities for payments for patients who are minor children, whose parents are divorced, rest with the parent who seeks the treatment (This parent is the guarantor.) Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of POSM.
- We bill participating insurance companies as a courtesy to you. If your insurance company requires your social security number to file a claim, you will be required to provide it or pay for services at time of service. **We require that payment of deductibles, co-pays, surgery deposits, non-covered items and co-insurance be paid at the time of service. You are financially responsible for services not covered by your insurance company.**
- We do not bill third party insurance companies such as Auto or Liability Insurance; payment is expected in full at time of service. We will provide you with the necessary paperwork and forms to you to submit your claim to your insurance carrier.
- For ERISA, Out-Of-Network and Self-Funded plans, and Workers Compensation I hereby assign and convey directly to Precision Orthopedics & Sports Medicine, as my designated authorized representative, all insurance reimbursement for services rendered by POSM regardless of its network participation status. I authorize POSM and its billing representatives to negotiate, discuss, appeal and in any other way communicate with my insurance company in determining the final payment for services I received. POSM and its billing representative has full authorization to accept or reject any proposed reimbursement proposal, act in whatever way necessary to accomplish the final adjudication of any and all claims, and the results of that determination is binding.
- If you have a balance after we receive payment from the insurance company, we will mail you a statement to the billing address you provide. Payment in full is due upon receipt. Patients with an outstanding balance 60 days or more overdue must make a payment arrangement prior to scheduling appointments.
- Appointment cancellations within 24 hours of the scheduled time may result in a \$35.00 charge. Failure to notify us 48 hours before cancelling a surgery may result in a \$100.00 charge. Returned checks for any reason will result in a \$35.00 charge.

I/we assign to POSM, and Health care providers, and authorized direct payment to Facility(s) all insurance benefits or Medicare benefits which may be entitled. This assignment includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injured caused by a third party.

I / we agree to pay Facility(s) for any and all charges not paid pursuant to this assignment. I have read and POSM Patient Consent, Prescription refill, and Financial Policy and agree to abide by its guidelines.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Representative

\_\_\_\_\_  
Date

## **Important Information About Provider/Patient Email**

As a patient of a Precision Orthopedics & Sports Medicine (POSM), you have the right to request we communicate with you by electronic mail (email). It is also your right to be informed in sufficient detail about the risks of communicating via email with your health care provider or office, and how POSM will use and disclose provider/patient email.

### **PLEASE READ THIS INFORMATION CAREFULLY**

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition. If you have an urgent or an emergency situation, you should not rely solely on provider/patient email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though provider/patient email is not available to you – and seek assistance by means consistent with your needs.

Email messages on your computer, your laptop, and/or your PDA have inherent privacy risks – especially when your email access is provided through your employer or when access to your email messages is not password protected.

Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the post office.

Email messages may be inadvertently missed. To minimize this risk, POSM or any of the DBA's will require that you respond appropriately to a test email message before we will allow health information about you to be communicated with you via email. You can also help minimize this risk by using only the email address that you are provided at the successful conclusion of the testing period to communicate with POSM.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. In order to forward or to process and respond to your email, individuals at POSM other than your health care provider may read your email message. Your email message is not a private communication between you and your treating provider. Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted.

At your health care provider's discretion, your email messages and any and all responses to them may become part of your medical record.

## Patient Request for Email Communications

**Communications over the Internet and/or using the email system are not encrypted and are inherently insecure. There is no assurance of confidentiality of information when communicated this way.** Nevertheless, you may request that we communicate with you via email. To do so, you must complete this form and return it to Precision Orthopedics & Sports Medicine (POSM).

**Please be advised that:**

- This Request applies only to the health care provider within Precision Orthopedics and Sports Medicine.** If you would like to request to communicate via email with another health care provider or office, you must complete a separate Request for that office.
- POSM will not communicate health information that is specially protected under state and federal law (e.g., HIV/AIDS information, substance abuse treatment records information, mental health information) via email even if we agree to communicate with you via email.
- Your Request will not be effective until you receive and respond appropriately to a test email message from POSM.

**Please provide the following information:**

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

Phone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please select the question you want to use (by checking the one of the boxes below) for your test email and provide your answer.

- The last four digits of my Social Security #: \_\_\_\_\_
- My mother's maiden name: \_\_\_\_\_
- My middle name: \_\_\_\_\_
- The street number of my residence: \_\_\_\_\_

**Please initial each blank and sign below:**

- I certify the email address provided on this Request is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address.
- I have received a copy of the IMPORTANT INFORMATION ABOUT PROVIDER/PATIENT EMAIL form, and I have read and understand it.
- I understand and acknowledge that communications over the Internet and/or using the email system are not encrypted and are inherently insecure; that there is no assurance of confidentiality of information when communicated this way.
- I understand that all email communications in which I engage may be forwarded to other providers, including providers not associated with POSM, for purposes of providing treatment to me.
- I agree to hold POSM and individuals associated with it harmless from any and all claims and liabilities arising from or related to this Request to communicate via email.
- I choose to waive the option for any email communications.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## **Notice of Privacy Practices**

### **Your Information. Your Rights. Our Responsibilities.**

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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.**

#### **You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

#### **We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

#### **Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.



- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

### **Our Uses and Disclosures**

#### ***How do we typically use or share your health information?***

We typically use or share your health information in the following ways.

#### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### ***How else can we use or share your health information?***

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

#### **Do research**

We can use or share your information for health research.

#### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

#### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

#### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

#### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

#### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. **Effective Date of this Notice 1-1-2018.**

#### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, it must be made in writing, and mailed to Precision Orthopedics & Sports Medicine, Attn: Administration, 2120 N. MacArthur Blvd., Suite 100, Irving, TX 75061.

**You will not be penalized for filing a complaint.**