ORTHOPEDIC SPINE AND SPORTS MEDICINE CENTER ♦2 FOREST AVE♦PARAMUS, NJ 07652

PATIENT QUESTIONAIRE

Patient's Name: Last First *(legal)*: Middle Initial:

Address:

City:	State:	Zip:	

Date of Birth:	Sex: ☐ Male ☐ Female	Preferred Daytime #

Home Phone #	Cellular #	Work #

Email Address:

Can a message be left at your home? ☐ Yes ☐ No Left on your answering machine? ☐ Yes ☐ No

Employer/Doctor

Employer's Name

Address:

Referring Doctor	Phone Number	**Primary Doctor**	Phone #

Patient Information

Race	**Marital Status**	**Employment**	**Ethnicity**	**Preferred Contact:**
☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Alaskan Native-American Indian ☐ More than one race ☐ Unreported/Refused	☐ Single ☐ Life Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Military ☐ N/A	☐ Hispanic ☐ Non Hispanic ☐ Not Reported Preferred Language:	☐ Home Phone ☐ Cell Phone ☐ Work ☐ Email Other:

Student
☐ Full-Time
☐ Part-Time
☐ Not Attending

Emergency Contact

Please give us an emergency contact that has a different phone number from yours

Name ☐ Male ☐ Female DOB

Relationship to Patient Telephone #

May we leave a message for you with this individual? ☐ Yes ☐ No

INSURANCE

**** Please present your insurance card to the receptionist so that a copy can be made for our records****

Primary Insurance:_____ ID# _____Group # _____

Type of Insurance: ☐ Managed Care ☐ PPO ☐ HMO ☐ Workers Comp ☐ No Fault Effective Date: _____

Subscriber's Name: _____ DOB _____

Relation to Patient ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Guardian ☐ Other

Employer Name: _____

Secondary Insurance _____ ID # _____Group # _____

Subscriber's Name: _____ DOB: _____

Relation to Patient ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Guardian ☐ Other

FINANCE

Insured / Responsible Party (who is responsible for payment if not patient)

Name Last: First (legal) Middle Initial:

Address (if different than patient)		
City:		
DOB:		

Signature: _____ Date: _____

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CONSENT FOR DIAGNOSIS/TREATMENT AND FINANCIAL AGREEMENT

I authorize the staff of Orthopedic Spine and Sports Medicine and those responsible for my care to administer and perform such treatment and procedures as are considered necessary or advisable in the diagnosis of this patient. I understand that the practice of Orthopedics is not an exact science and acknowledge that no guarantees have been made as to the result of my care. I also understand that this consent allows for the exchange of medical information relevant to my care with other health care providers and pharmacies.

FINANCIAL AGREEMENT

I, the undersigned, acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that Orthopedic Spine and Sports Medicine is providing care and treatment to myself and I agree to pay charges for such care and treatment. I understand that insurance benefits are subject to verification and that I am responsible for charges not covered by insurance in accordance with the service polices, rate and terms established by the center. I understand that if any of my insurance carriers require pre-certification or pre-approval of my admission that I accept full responsibility for obtaining such authorization. I also understand that balances resulting from my failure to obtain such authorization from my carrier are my responsibility.

RELEASE OF MEDICAL INFORMATION

I, the undersigned, authorize and direct Orthopedic Spine and Sports Medicine, having treated me, to release to governmental agencies, insurance carriers , or others who are financially liable for my care, all information needed to substantiate payment for such care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, assign, transfer, and set over to Orthopedic Spine and Sports Medicine sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my care to cover the costs and the care and treatment rendered to myself or my dependent in said center.

MEDICARE AUTHORIZATION AND ASSIGNMENT

I, the undersigned, certify that the information given by me in applying for payment under TITLE XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its Intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I certify that I am over the age of 18 years or that I am under the age of 18 years but am married

Patient Signature: **Date**

Witnessed by: **Date**

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OSSMC HIPAA COMMUNICATION FORM

Authorization: ☐ The Patient ☐ Legal Guardian Name: _____

The Physician/practice may use or disclose the following protected health information:(**i.e. all, labs only, diagnosis only**)

The following protected health information is specifically exempted from disclosure:(**i.e. not medications, not diagnosis**)

☐ Doctor agrees to restrictions

The purpose of the use/disclosure is: (**i.e. allow family members to talk with doctor**)

This authorization is in force until: (**1 month, 1 year, no limit**)

Disclosure to: (**who can we discuss information with?**)

☐ Any health care provider or facility

☐ Spouse

☐ Children

☐ OK to leave voice message

Others:

I acknowledge that I have been given an opportunity to read a copy of the Notice of Privacy Practices for OSSMC

Signature: _____ Date: _____

Patient Name: _____ DOB : _____

Phone Number: _____

HIPAA PRIVACY NOTICE

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.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your **protected health information (PHI)**. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law (the Health Insurance Portability and Accountability Act of 1996 or HIPAA) to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights concerning your PHI
- Our obligation concerning the use and disclosure of your PH

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer 2 Forest Ave Paramus, NJ Phone: 201-587-1111

C. Uses and Disclosures of Health Information

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you now or in the future.

We may also use health information about you to call you or send you a letter to remind you about an appointment, to follow up with diagnostic tests results, or to provide you with information about other treatment and care that could benefit your health.

Access to Medication History from pharmacies to update medical history.

For payment: We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed and payment may be collected from you, an insurance company or a third party.

For healthcare operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. Every effort will be made to insure anonymity.

D. Other Disclosures

Business Associates: We will share your PHI with third party associates that perform various activities for the clinic. Whenever any arrangement between our clinic and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Communication with others involved with your care: Our health professionals may, in the event you are incapacitated or in an emergency circumstance, using their judgment, disclose to a family member, or other relative, close personal friend or any other person you identify, health information directly relevant to that person's involvement in your care or payment related to your care.

Research: Under certain circumstances, we may use and disclose health information about you from your medical record for research purposes. All research projects, however, are subject to a special approval process designed to protect the privacy of your health information.

Required by law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such disclosures.

Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled or withdrawn, needs repairs or replacement
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are require or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful purpose.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement. Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent or lessen the threat.

Military: Our practice may disclose your PHI if you are a member of the U.S. Armed Forces, a veteran, or a member of foreign military forces for activities deemed necessary by appropriate military commend authorities, including the Department of Veteran's Affairs for the purpose of your eligibility for or entitlement to certain benefits provided by law.

National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you (b) for the health, safety and security of the institution, and its officers and employees and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs to the extent necessary to comply with applicable laws.

HIPAA PRIVACY NOTICE

Required Uses and Disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirement of Section 164.500 et. seq.

We will **not** use information in your records for marketing purposes.

Other uses and disclosures from your medical record will be made only with your written authorization or approval.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, please use the contact information below to make an appointment to complete the form. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing using the contact information below. Your request must describe in a clear and concise fashion:

- the information you wish restricted;
- whether you are requesting to limit our practice's use, disclosure or both; and
- to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. However, you may not obtain psychotherapy notes or information compiled in reasonable anticipation of a civil, criminal or administrative action or proceeding. You must submit your request in writing using the contact information below in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. To request an amendment, your request and reason for the request must be made in writing using the contact information below. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) was not created by our practice, unless the individual or entity that created the information is not available to amend the information.

HIPAA PRIVACY NOTICE

5. Accounting of Disclosures. All of our patients have the right to request an accounting of disclosures,. An accounting of disclosures is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor's sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing using the contact information below. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date the accounting of disclosures is requested and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time by contacting us utilizing the contact information below.

7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with our practice, use the contact information below.

8. **Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Contact Information:

Office: 2 Forest Ave Paramus, NJ Phone: 201-587-1111