Paulo S. Bicalho, MD
Brett R. Grebing, MD

6812 State Route 162, Ste. 123
Maryville, IL 62062
618-288-9460 phone
618-288-9461 fax

The Center for Advanced Orthopedics

Patient's Name:_____ DOB: ___/___/___ Age: _____Male:____ Female:____

SS#: _____ Primary Insurance Carrier_____

Street Address: _____

City:_____ State: _____ZIP: _____

Home Phone:_____ Cell Phone: _____

E-Mail Address: _____

Preferred Pharmacy: _____Phone:_____
(Name & City)

Patient's Employer Info:

Employer:_____

Work Phone:_____

Spouse's Employer Info:

Employer: _____

Work Phone:_____

If work related accident, complete info below:

Was this a work related injury? _____If yes, do you have authorization for today? _____Date of Injury:_____

Workman's Comp Carrier: _____

Phone #: _____ Fax #: _____ Claim #: _____

Address to submit claims: _____

CC: _____ Date of Injury: _____

Insurance Guarantor Information

Guarantor Name: _____Relationship to Patient: _____

Address: _____

DOB: ____/____/____ SS#: _____ Phone: _____

In Case of Emergency, Please Contact:

Name: _____Phone:_____ Relationship: _____

Your signature confirms that all of the above information is correct and authorizes The Center for Advanced Orthopedics to correspond with the physicians listed above. I authorize the release of information to my insurance company, including Medicare. I also authorize insurance benefits to be paid directly to The Center for Advanced Orthopedics, a division of Maryville physicians services. I understand that I am responsible for all deductibles and co-insurance, and non-covered services that may be required. In addition, I agree to pay for any additional charges related to the cost of collection in the event I fail to pay my bill. If signed by a guardian or parent, this is also an authorization for medical treatment of a minor. A photocopy of this document is to be considered as valid and original..

Patient/Parent/Guardian Signature: _____Date: _____

REFERRING DOCTOR INFORMATION

NAME: _____
SPECIALTY: _____
CITY/STATE: _____PH#:_____

PRIMARY DOCTOR INFORMATION

NAME: _____
SPECIALTY: _____
CITY/STATE: _____PH#:_____

HISTORY OF YOUR CURRENT ORTHOPAEDIC PROBLEM

YOUR HEIGHT: _____'_____" WT _____LBS

Please write your current problem here: _____

THE PROBLEM PRIMARILY INVOLVES (Check all that apply and circle side)
___NECK___SPINE___BACK___SHOULDER R/L___UPPER ARM R/L)___ELBOW R/L
___FOREARM R/L___WRIST R/L___HAND R/L___PELVIS___HIP R/L___THIGH R/L
___KNEE R/L___LEG R/L___ANKLE R/L___FOOT R/L___OTHER _____

HOW LONG HAS THIS BEEN PRESENT? SINCE ____/____/____ OR FOR ___ ___DAYS/MONTHS/YEARS

WHAT CAUSED PROBLEM TO START? ___UNKNOWN REASON___ACCIDENT (___MOTOR VEHICLE___MOTORCYCLE
___FALL___OTHER (PLEASE DESCRIBE)_____

DID THE PROBLEM START AT WORK? ___NO ___YES WILL A WORKERS COMPENSATION CLAIM BE FILED?___NO___YES

HOW DO YOU DESCRIBE YOUR PAIN? ___ACHING___BURNING___SHARP/STABBING___NUMBNESS/TINGLING
___OTHER_____

HOW SEVERE IS THE PROBLEM? ___MILD___MODERATE___SEVERE

IS IT GETTING BETTER OR WORSE? ___BETTER___WORSE___SAME___ OVER LAST____HOURS/DAYS/WEEKS/MONTHS

WHAT MAKES PROBLEM BETTER/WORSE? BETTER_____WORSE_____

HAVE YOU RECENTLY BEEN EVALUATED IN AN EMERGENCY ROOM FOR THIS PROBLEM? ___NO___YES DATE:___/___/____ DAYS/MONTHS AGO
HOSPITAL OF E/R VISIT _____
TREATMENT IN E/R? ___X-RAYS (DESCRIBE RESULTS)_____
___SPLINT___CRUTCHES___SLING___FRACTURE "SET" ___OTHER_____

PREVIOUS NON-SURGICAL TREATMENTS FOR THIS PROBLEM HAVE INCLUDED: ___NO PREVIOUS TREATMENT___PHYSICAL THERAPY___INJECTIONS___ULTRASOUND
___CAST___BRACE___MANIPULATION___OTHER_____

DESCRIBE ANY PREVIOUS SURGERY FOR THIS PROBLEM BELOW	DOCTOR	DR's SPECIALTY	CITY

LIST OTHER DOCTORS YOU HAVE SEEN FOR THIS PROBLEM	TREATMENT	DR's SPECIALTY	CITY

MEDICATIONS TAKEN FOR THIS PROBLEM	NAME OF MEDICATION(S)	DOSE	FOR HOW LONG
___ANTI-INFLAMMATORIES			
___NARCOTIC PAIN RELIEVERS			
___OTHER _____			

X-RAYS AND TESTS FOR THIS PROBLEM	RESULTS	DATE	WHERE
___PLAIN X-RAYS			
___MRI			
___CT SCAN			
___BONE SCAN			
___OTHER			

PAST MEDICAL HISTORY

CHECK ALL ITEMS THAT APPLY AND DESCRIBE BELOW IF NECESSARY. **IF NO ITEMS ON A LINE APPLY, CIRCLE NONE.**

___ANESTHESIA PROBLEMS: IF YES, PLEASE DESCRIBE_____ NONE
___HEART PROBLEMS: ___HEART ATTACK ___HEART FAILURE ___STROKE NONE
___CIRCULATION PROBLEMS: ___HIGH BLOOD PRESSURE ___POOR CIRCULATION NONE
___LUNG PROBLEMS: ___EMPHYSEMA ___ASTHMA ___LUNG DISEASE ___PNEUMONIA ___TUBERCULOSIS NONE
___DIABETES: IF YES, WHEN DIAGNOSED _____ ___CONTROLLED WITH INSULIN___ORAL MEDS NONE
___NEUROPATHY OR LOSS OF FEELING: ___HANDS ___FEET NONE
___GLAND PROBLEMS: ___THYROID ___ADRENAL ___PITUITARY NONE
___BLOOD PROBLEMS: ___BLEEDING DISORDER ___ANEMIA NONE
___CANCER: (TYPE _____) NONE
___STOMACH PROBLEMS: ___STOMACH ULCERS ___HIATAL HERNIA ___GASTRIC REFLUX NONE
___KIDNEY PROBLEMS: ___KIDNEY FAILURE ___KIDNEY STONES NONE
___LIVER PROBLEMS: ___HEPATITIS ___CIRRHOSIS NONE
___MENTAL ILLNESS: ___DEPRESSION ___SEIZURES ___ALCOHOLISM NONE
___BONE/JOINT PROBLEMS: ___FRACTURES ___OSTEOARTHRITIS ___RHEUMATOID ARTHRITIS ____GOUT NONE
___AIDS ___HIV NONE
___BLOOD CLOTS: ___BLOOD CLOT IN LEG ___BLOOD CLOT IN LUNG NONE
___DESCRIPTIONS/OTHER:

_____

_____

_____

MEDICATIONS **(OTHER THAN THOSE INDICATED PREVIOUSLY)** **_____NO OTHER MEDICATIONS**

MEDICATION	DOSE/STRENGTH	FREQUENCY (HOW OFTEN YOU TAKE)

ALLERGIES TO MEDICATIONS **_____NO KNOWN DRUG ALLERGIES**

MEDICATION	*REACTION (CHECK ALL THAT APPLY)*
	__RASH__SWELLING__WHEEZING__SHOCK__STOMACH UPSET__OTHER_____
	__RASH__SWELLING__WHEEZING__SHOCK__STOMACH UPSET__OTHER_____
	__RASH__SWELLING__WHEEZING__SHOCK__STOMACH UPSET__OTHER_____
	__RASH__SWELLING__WHEEZING__SHOCK__STOMACH UPSET__OTHER_____
	__RASH__SWELLING__WHEEZING__SHOCK__STOMACH UPSET__OTHER_____

PAST SURGICAL HISTORY (OTHER THAN THOSE INDICATED PREVIOUSLY) **_____NO OTHER PRIOR SURGERY**

OPERATION	DATE	SURGEON

FAMILY HISTORY (CHECK ALL THAT APPLY) **___NONE APPLY**

___HEART TROUBLE ___DIABETES ___BLEEDING PROBLEMS ___STROKE ___HIGH BLOOD PRESSURE ___ARTHRITIS
___GOUT ___SEIZURES ___CANCER ___KIDNEY TROUBLE ___SPINE PROBLEMS ___MENTAL ILLNESS ___ALCOHOLISM
___LUNG PROBLEMS ___OTHER _____

SOCIAL HISTORY (CHECK ALL THAT APPLY)

WORK STATUS OCCUPATION_____ __WORKING__UNEMPLOYED__RETIRED__DISABLED __ON LEAVE

Race: _____

Ethnicity: _____

Preferred Language: _____

MARITAL STATUS: ___MARRIED___SINGLE___CO-HABITATING___DIVORCED___WIDOWED

CHILDREN: ___BOYS ___GIRLS

LIVE WITH: ___ALONE___SPOUSE___SIGNIFICANT OTHER___CHILDREN___ROOMMATE___OTHER

TOBACCO USE: ___NEVER___CIGARETTES___CIGAR___PIPE___CHEW

___PACKS PER DAY FOR ____ YEARS (TOTAL) QUIT ____ YEARS AGO

ALCOHOL USE: ___NEVER___RARE___SOCIAL___FREQUENTLY (MORE THAN TWICE A WEEK)

___ALCOHOLIC___RECOVERING ALCOHOLIC

CAFFEINE USE: ___YES___NO

DRUG USE: ___NEVER___IN PAST___CURRENTLY TYPES OF DRUGS: _____

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY AND DESCRIBE BELOW IF NECESSARY, **IF NO ITEMS ON LINE APPLY, CIRCLE NONE**)

DO YOU CURRENTLY HAVE OR HAVE YOU HAD PROBLEMS WITH:

___FEVER___CHILLS___RECENT WEIGHT LOSS___RECENT WEIGHT GAIN NONE

___EYES: ___READING GLASSES ___CHANGE OF VISION NONE

___EARS: ___HEARING LOSS ___EAR PAIN ___VERTIGO (DIZZINESS) NONE

___NOSE/MOUTH/THROAT: ___NOSEBLEEDS___HOARSENESS___BLEEDING GUMS___TOOTH/GUM TROUBLE NONE

___LUNGS: ___COUGH___SHORTNESS OF BREATH___PNEUMONIA___ASTHMA___EMPHYSEMA NONE

___STOMACH: ___NAUSEA___VOMITING___STOMACH PAIN___ULCERS NONE

___BOWELS: ___FREQUENT DIARRHEA___FREQUENT CONSTIPATION___HEMORRHOIDS NONE

___URINARY TRACT: ___FREQUENT OR BURNING URINATION___DIFFICULTY STARTING URINATION NONE

___GLANDS: ___DIABETES___HYPERACTIVITY___GROWTH CHANGES NONE

___HEART: ___CHEST PAIN___PALPITATIONS___ABNORMAL HEARTBEAT___SWOLLEN ANKLES NONE

___SKIN RASHES: ___SKIN ULCERS___SCARS___DERMATITIS NONE

___BRAIN: ___SEIZURES___FREQUENT HEADACHES___MEMORY LOSS___BLACKOUTS NONE

___PSYCHOLOGICAL PROBLEMS: ___DEPRESSION___HALLUCINATIONS___FREQUENT ANXIETY ___SLEEP DISTURBANCES NONE

___NEUROPATHY OR LOSS OF FEELING: ___HANDS___FEET NONE

___BLOOD: ___BLEEDING___ANEMIA___SWOLLEN LYMPH NODES NONE

___NON-DRUG ALLERGIES: ___ALLERGIES TO FOOD___SEASONAL ALLERGIES___OTHER NON-DRUG ALLERGIES NONE

___GYNECOLOGIC PROBLEMS: ___IRREGULAR PERIODS___VAGINAL DISCHARGE___FREQUENT SPOTTING NONE

___DESCRIPTIONS/OTHER:

_____

_____

BECAUSE OF YOUR ORTHOPAEDIC PROBLEM(S) DO YOU PLAN TO FILE: ___A LAWSUIT___A WORKMAN'S COMPENSATION CLAIM___NEITHER

*****FOR OFFICE USE ONLY*****

I HAVE READ AND CONFIRMED THE ABOVE INFORMATION WITH THE PATIENT.

PHYSICIAN SIGNATURE: _____DATE_____/_____/_____

PHYSICIAN SIGNATURE: _____DATE_____/_____/_____

PHYSICIAN SIGNATURE: _____DATE_____/_____/_____

PHYSICIAN SIGNATURE: _____DATE_____/_____/_____

PHYSICIAN SIGNATURE: _____DATE_____/_____/_____

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The Center for Advanced Orthopedics

Billing / Collection Policy and Procedures

Medicare and Other Insurance Claim Filing

If you are a Medicare patient and have provided us with your Medicare billing information, we will file your claim automatically. If you have other insurance and have provided us with the appropriate name and address of your carrier, The Center for Advanced Orthopedics ("CAO") will provide your insurance carrier with the necessary forms to process your claim.
If we do not have this information, you will be responsible for your bill. If you need additional assistance, the Business Office can provide any other necessary forms once your bill has been paid.

Billing Statements

After your insurance has adjudicated your claim, you will receive an itemized statement listing the amount owed by you along with your itemized account charges, receipts, and credits.

Payment

All charges are due and payable at the time of service or upon receipt of the initial statement.
Payments can be made by cash, check, MasterCard, Discover Card, or VISA. Checks should be made payable to The Center for Advanced Orthopedics. In making payment, regardless of source, please include the lower portion of your statement to ensure that your payment is credited properly.

Finance Charges

At the current time we do not typically assess a Finance Charge. However, we reserve the right to charge one if any part of your account balance is unpaid 90 Days after the initial billing

Your Billing Rights

This notice contains important information about your billing rights and our responsibilities under the Fair Credit Billing Act in case of errors or questions about your bill.

Notify us in case of errors or questions about your bill

If you think your bill is wrong or you need more information about a transaction on your bill, please contact us or our billing office at 866-724-6658.

Assignment of insurance benefits

I hereby authorize payment of insurance benefits otherwise payable to me, directly to CAO as the provider of services rendered not to exceed the providers charges. I understand that I am financially responsible for charges not covered by this authorization. It is further agreed that any credit balance resulting from overpayment may be applied to other balances.

Receipt of notice of privacy practices acknowledgement form

I hereby acknowledge that I received the Billing / Collection Policy and Procedures of CAO, which sets forth the ways in which my protected health information may be used or disclosed and outlines my rights with respect to such information.

Signature_____Date_____

Printed Name_____

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The Center for Advanced Orthopedics

ACKNOWLEDGEMENT
Receipt of Privacy Practices

_____ _____
Patient Name Date

By signing below, I acknowledge that I have received the Notice of Privacy Practices from The Center for Advanced Orthopedics (CAO).

Protected Health Information (PHI) HIPPA consent allows CAO to communicate with immediate family members, other healthcare professional or healthcare facility(s) to assist in your healthcare.

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, healthcare professional or healthcare facility or other person responsible for your care, about your location about your general condition or your health.

Communication with Family/Personal Care Representative/Guardian
Using our best judgment, we may disclose to an immediate family member, other relative, or close personal friend, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. This information may be written or by telephone.

You may identify specific individual(s) that we may share medical information with verbally, in writing or by phone:
_____
_____
_____

Specific description of the information to be used or disclosed, including the specific purpose:
_____
_____

Please complete the information below:

_____I authorize CAO to share medical information as indicated above.
_____I **DO NOT** authorize CAO to share medical information as indicated above.

Signed _____ Date _____
Patient/Patient Guardian

Office Staff _____ Date _____

THIS DISCLOSURE WILL NOT EXPIRE UNLESS WE ARE NOTIFIED. YOU MAY CONTACT OUR OFFICE TO CHANGE YOUR PROTECTED HEALTH INFORMATION STATUS AT ANY TIME.

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The Center for Advanced Orthopedics

Privacy Policy

The following is the privacy policy ("Privacy Policy") of The Center for Advance Orthopedics("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:
(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

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. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain

emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that arequest contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to The Center for Advanced Orthopedics.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to The Center for Advanced Orthopedics.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to, The Center for Advanced Orthopedics. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent The Center for Advanced Orthopedics. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact us at the address, telephone number, or e-mail address listed above.

I hereby acknowledge that I received the Notice of Privacy Practices of, which sets forth the ways in which my protected health information may be used or disclosed an outlines my rights with respect to such information.

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Signature_____ Print Name_____ Date_____