

**Tier Orthopedic Associates, PC
240 Riverside Drive
Johnson City, NY 13790
607-798-9356**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes, treatment, payment and health care operations.

- **Treatment:** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment:** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health care operations:** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information , including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office by speaking with our Privacy Official or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT.

I Understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Tier Orthopedic Associates, P.C. has the right to change the Notice of Privacy Practices from time to time and that I may contact Tier Orthopedic Associates, P.C. at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I do hereby acknowledge that I have received a copy of the Notice of Privacy Practice.

Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

Relationship to patient: _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature and acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below.

Reason: _____

Signature: _____ Date: _____

TIER ORTHOPEDIC ASSOCIATES, P.C.

240 Riverside Drive Johnson City, NY 13790

Telephone 798-9356

Social Security No. _____

PATIENT INFORMATION

PATIENT NAME:

First Name _____ Middle Initial _____

Last Name _____

Patient's Address _____

City _____ Zip Code _____

Phone No. _____ Age _____ Date of Birth _____

Sex: Male _____ Female _____

Primary Care Physician/Referring Physician:

Patient's Employer _____

Work Phone _____

Spouse's Name or Nearest Relative _____

Address _____

Phone No. _____

Employed by _____

IF CHILD:

Parent's Name _____

Employed by _____

WHAT ARE YOU BEING SEEN FOR?

Right _____ Left _____ Body Part _____

WERE X-RAYS TAKEN? Yes ___ No ___ Where _____ When _____

WERE MRI'S TAKEN? Yes ___ No ___ Where _____ When _____

WAS EMG DONE? Yes ___ No ___ Where _____ When _____

INSURANCE INFORMATION:

WERE YOU INJURED AT WORK?

Yes ___ No ___ Date of injury _____

Comp Carrier _____

WERE YOU INJURED IN AN AUTO ACCIDENT?

Yes ___ No ___ Date of Accident _____

PRIMARY INSURANCE CO. _____

ID No. _____

Subscriber _____

SECONDARY INSURANCE CO. _____

ID No. _____

Subscriber _____

OFFICE USE ONLY

DOCTOR _____

DATE SEEN _____

Initial _____

MEDICAL INSURANCE WAIVER

I, THE UNDERSIGNED, AGREE TO THE PROVISION THAT IF MY MEDICAL INSURANCE DOES NOT COVER ANY AND ALL EXPENSES INCURRED DURING THE COURSE OF MY MEDICAL TREATMENT, I AM RESPONSIBLE FOR SAID PAYMENTS.

PATIENT OR GUARDIAN SIGNATURE

DATE _____

Payment Authorization to Provider _____

FOR OFFICE USE ONLY Account No. _____

X-Ray No. _____

Date	Name	Birthdate	Age
SSN	Male	Female	Telephone

Primary Care Physician/Referring Physician _____

Were x-rays brought with you? _____ Where taken? _____

Nearest Relative _____ Relationship _____ Phone _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the result of a(n): Please check all that apply:
 Car Accident Work Accident Accident Other

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication

Are all immunizations up to date? Yes No
 If no, which immunizations are due? _____

REVIEW OF SYMPTOMS

Do you have any (Please circle positives and explain):

	Circle	Describe all "Yes" responses
CONSTITUTION: chills, fever, unintentional weight loss	No Yes	_____
EYES: eye symptoms	No Yes	_____
ENMT: ear, nasal, mouth or throat symptoms	No Yes	_____
CV: blood clots, chest pain, heart problems, high blood pressure	No Yes	_____
RESP: difficulty breathing	No Yes	_____
GI: change in bowels, GERD, hepatitis, liver problems, acid reflux	No Yes	_____
GU: bladder infection, kidney disease, renal failure, urinary stream abnormality	No Yes	_____
MUSCULO: arthritis	No Yes	_____
SKIN: skin, hair, nail symptoms	No Yes	_____
NEURO: imbalance, lightheadedness, numbness/tingling, stroke	No Yes	_____
PSHYC: anxiety, depression, mental illness, stress	No Yes	_____
ENDOCRINE: diabetes, thyroid	No Yes	_____
HEMA/LYMPH: bleeding, blood transfusions	No Yes	_____
ALLERGY/IMMUNO: AIDS, HIV	No Yes	_____
CANCER	No Yes	_____

Reviewed and updated _____

** PLEASE SEE OTHER SIDE**

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? NO YES

Have any problems with anesthesia? NO YES

Describe: _____

FAMILY HISTORY (IMMEDIATE FAMILY ONLY):

Member	Alive	Deceased	Age	Health status or cause of death

Do any diseases run in your family-Describe:

SOCIAL HISTORY

Work in the home Employed (occupation _____) Student Daycare Retired

Currently Working Yes No

Regular Duty Yes No Restricted Duty Yes No If Yes, please state restrictions _____

Who took you out of work or put you on light duty? _____

Single Married Divorced Separated Widowed

Children? No Yes # _____

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

History of substance abuse? No Yes What? _____

Smoke currently? No Yes _____ Packs per day for _____ years.

Quit smoking? This year > 1 year > 5 years > 10 years Height: _____ Weight: _____

Previously smoked _____ packs per day for _____ years.

Drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year

INSURANCE MEDICAL RELEASE/ASSIGNMENT:

I hereby authorize release of medical information necessary to process my insurance claim, and I also hereby authorize payment directly to the physician for benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization.

Patient Signature: _____ Date: _____

Reviewed by: _____, M.D. Date: _____

TIER ORTHOPEDIC ASSOCIATES

**240 Riverside Drive
Johnson City, NY 13790**

Authorization to Share Information

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

PATIENT NAME: _____ **DOB:** _____

Leave appointment and billing messages on/with: Leave medical information messages on/with:

Answering machine?	___ Yes	___ No	Answering machine?	___ Yes	___ No
Office Voice Mail?	___ Yes	___ No	Office Voice Mail?	___ Yes	___ No
With another person?	___ Yes	___ No	With another person?	___ Yes	___ No
Send through the mail?	___ Yes	___ No	Send through the mail?	___ Yes	___ No
Send via email?	___ Yes	___ No	Send via email?	___ Yes	___ No
Cell Phone?	___ Yes	___ No	Cell Phone?	___ Yes	___ No

If you answered YES to allowing us to discuss your appointment, billing and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

<u>Name:</u>	<u>Relationship:</u>	<u>Phone:</u>	<u>Cell Phone:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional HIPAA Contact instructions:

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: _____

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP: _____

DATE: _____

This authorization will expire one year from the date of signature, unless otherwise notified.