

INITIAL MEDICAL HISTORY FORM

NAME: _____ DATE: _____ SS# _____ AGE: _____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE #: _____

HISTORY OF PRESENT ILLNESS/CONDITION

WHY ARE YOU SEEING THE DOCTOR TODAY: _____

DATE OF ACCIDENT OR ONSET, IF APPLICABLE: _____

HOW WERE YOU INJURED? _____

WHERE DOES IT HURT, IF APPLICABLE? _____

IF IN PAIN, HOW SEVERE IS THE PAIN USING SCALE FROM 1 - 10? _____

WHAT MAKES IT BETTER AND/OR WORSE? _____

PAST MEDICAL HISTORY

WHAT MEDICATIONS DO YOU TAKE DAILY? (DRUG NAME ONLY)

DO YOU HAVE ANY ALLERGIES? (SPECIFIC TO MEDICATIONS, ASPIRIN OR DYES)

ARE YOU RIGHT () OR LEFT HANDED () CAN YOU POSSIBLY BE PREGNANT? YES () NO ()

DO YOU NOW OR HAVE YOU IN THE PAST HAD ANY OF THE FOLLOWING:

HEART DISEASE	NO () YES ()	BLEEDING OR BRUISING PROBLEMS	NO () YES ()
HIGH BLOOD PRESSURE	NO () YES ()	HIGH CHOLESTEROL	NO () YES ()
DIABETES	NO () YES ()	URINARY DISORDERS	NO () YES ()
THYROID	NO () YES ()	DEEP VEIN THROMBOSIS	NO () YES ()
STOMACH ULCER	NO () YES ()	LUNG OR BREATHING PROBLEMS	NO () YES ()
CANCER	NO () YES ()	RASHES OR NON-HEALING LESION	NO () YES ()
EPILEPSY	NO () YES ()	PULMONARY EMBOLUS	NO () YES ()
ARTHRITIS	NO () YES ()		

HAVE YOU HAD ANY SURGERY IN THE PAST? IF YES, LIST TYPE AND DATE OF SURGERY : _____

HAVE YOU HAD ANY COMPLICATIONS WITH ANESTHESIA? IF YES, PLEASE EXPLAIN: _____

HAVE YOU BEEN HOSPITALIZED FOR A PROBLEM OTHER THAN LISTED ABOVE? IF YES, PLEASE SPECIFY CONDITION: _____

FAMILY HISTORY

FAMILY MEMBER	ALIVE/DECEASED	AGE	IF DECEASED, WHAT WAS THE CAUSE?
FATHER	A / D	_____	_____
MOTHER	A / D	_____	_____

SOCIAL HISTORY

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: S M W D

SMOKE CURRENTLY? YES () NO () _____ PACKS PER DAY FOR _____ YEARS

DRINK ALCOHOL? YES () NO () AMOUNT PER WEEK _____

WITHIN THE LAST 30 DAYS HAVE YOU USED: MARIJUANA, COCAINE, NARCOTICS OR ANY OTHER MIND-ALTERING SUBSTANCES? (I.E. STREET DRUGS) YES () NO ()

IF YES, WHAT HAVE YOU USED? _____

ARE YOU CURRENTLY EMPLOYED? YES () NO () IF NO, HOW LONG HAVE YOU BEEN UNEMPLOYED?

WHAT IS YOUR OCCUPATION? _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ R/L Handed: _____

Referring Physician: _____ Height: _____ Weight: _____

Is this a work related injury or illness? Yes No

Is this an accidental injury? Yes No Fall Car Accident

If this is a car accident, were you:

wearing your seat belt? Yes No

the driver? Yes No

the passenger? front rear

rear-ended broad-sided side-swiped head-on collision

Date of injury: _____

Describe what happened (mechanism of injury): _____

When did you first notice the pain? _____

Was the onset of your pain sudden or gradual? _____

Did you go to the Emergency Room? Yes No

Were you treated? Yes No

Were any tests performed? Yes No If yes: _____

What treatment did you receive? _____

List other physicians who have treated you for this problem: _____

Which of the following diagnostic tests have been performed for this problem?

X-rays

CT Scans

MRI Scans

EMG/Nerve conduction Studies

Discogram or Myelogram

Have you ever had a similar problem with this type of pain? Yes No

If yes, did you ever completely recover from this problem? Yes No

Have you had any previous medical or surgical treatment for this condition prior to your current injury? Yes No

Please describe: _____

Are you currently working? Yes No

Are you currently working full duty? Yes No Light duty? Yes No

How many hours per day do you work? _____

What is your occupation? _____

What are your job responsibilities (including lifting requirements)? _____

If not working, how long have you been out of work? _____

Have you tried to return to work? Yes No When? _____

Is there a Rehab Nurse or Counselor or Vocational Specialist working with you? Yes No
Who? _____

Is there a lawyer involved in your case? Yes No Name: _____

Have you applied for social security disability? Yes No

Are you receiving social security benefits? Yes No

PAIN DESCRIPTIVES

Describe your pain: (Examples: sharp, stabbing, shooting, burning, aching, tingling, numbness, pulsating, etc.) _____

Is the pain constant, intermittent or occasional? _____

How many hours per day do you have the pain? _____

How many days per week do you have the pain? _____

What activities are most affected by your pain? _____

Activity level is:

- unchanged
- pain with manual labor
- diminished
- unable to perform manual labor
- significantly restricted
- unable to perform daily household chores

Where is your worst pain? neck back R/L leg R/L arm

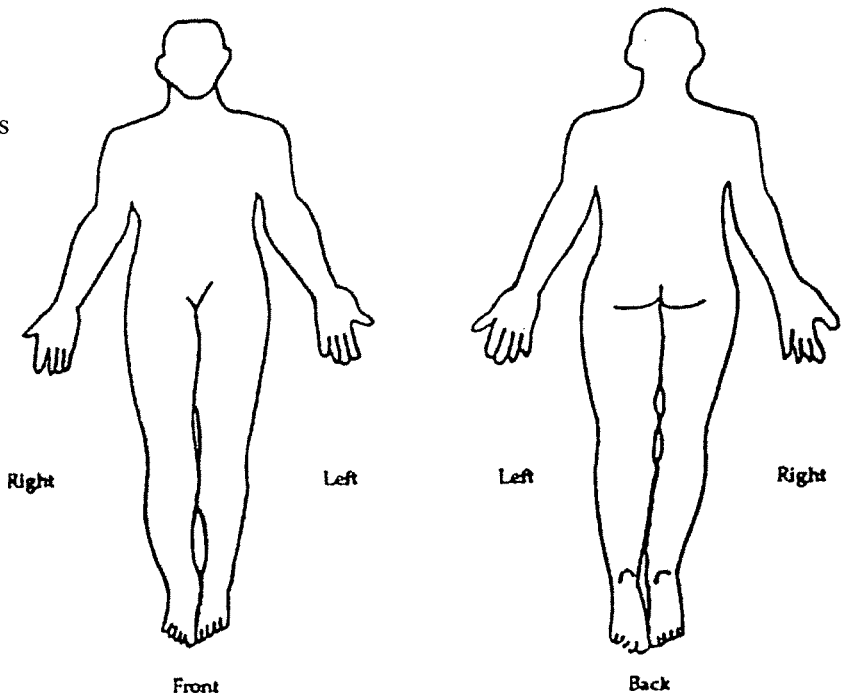
Please rate your pain (on a scale of 1-10). Please circle appropriately:

	No Pain	Minimal	Moderate	Intense	Emergency
Neck	0	1 2 3	4 5 6	7 8 9	10
Back	0	1 2 3	4 5 6	7 8 9	10
Arm	0	1 2 3	4 5 6	7 8 9	10
Leg	0	1 2 3	4 5 6	7 8 9	10

Pain Diagram: Please make the areas of your pain.

You may use the key below to indicate different kinds of pain sensations.

- Key: → = shooting
/// = stabbing
xxx = aching
ooo = throbbing
●●● = pins & needles
--- = burning



What makes your pain better? *(Please check all that apply)*

- | | | | | |
|-------------------------------------|-----------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> lying down | <input type="checkbox"/> walking | <input type="checkbox"/> sitting | <input type="checkbox"/> standing | <input type="checkbox"/> medication |
| <input type="checkbox"/> sleep | <input type="checkbox"/> heat/ice | <input type="checkbox"/> massage | <input type="checkbox"/> exercise | <input type="checkbox"/> stretching |
| <input type="checkbox"/> traction | <input type="checkbox"/> TENS | <input type="checkbox"/> forward bending | <input type="checkbox"/> backward bending | <input type="checkbox"/> compression |

Other: _____

What makes your pain worse? *(Please check all that apply)*

- | | | | | |
|--|-------------------------------------|-----------------------------------|----------------------------------|---|
| <input type="checkbox"/> standing | <input type="checkbox"/> sitting | <input type="checkbox"/> walking | <input type="checkbox"/> bending | <input type="checkbox"/> driving |
| <input type="checkbox"/> lack of sleep | <input type="checkbox"/> lying down | <input type="checkbox"/> lifting | <input type="checkbox"/> weather | <input type="checkbox"/> housework activity |
| <input type="checkbox"/> reaching overhead | <input type="checkbox"/> coughing | <input type="checkbox"/> sneezing | <input type="checkbox"/> tension | <input type="checkbox"/> arising from chair |

Other: _____

Do you have severe night time pain? Yes No

Do you wake up in the middle of the night because of pain? Yes No If yes, how many times? _____

Do you take sleeping medications? Yes No

Do you have difficulty falling asleep at night? Yes No

Average number of hours you sleep per night? _____

Do you experience any associated symptoms such as:

- | | | | |
|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> weakness in arms or legs | <input type="checkbox"/> problems with sexual functions | <input type="checkbox"/> vomiting | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> numbness/tingling of arms or legs | <input type="checkbox"/> headaches | <input type="checkbox"/> dizziness | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> leg pain with walking | <input type="checkbox"/> depression | <input type="checkbox"/> fatigue | |
| <input type="checkbox"/> leg pain not relieved by rest | <input type="checkbox"/> anxiety | <input type="checkbox"/> fever | |
| <input type="checkbox"/> bowel dysfunction | <input type="checkbox"/> balance disturbance | <input type="checkbox"/> chills | |
| <input type="checkbox"/> bladder dysfunction | <input type="checkbox"/> nausea | <input type="checkbox"/> night sweats | |

Which of the following treatments have you had for this condition?

- Physical Therapy *(including ultrasound, hot packs, traction, electrical stimulation, massage, exercise)*
- TENS Unit
- Traction
- Biofeedback
- Chiropractic
- Chiropractic Adjustments
- Psychological Supports
- Braces / supports
- Back School Education
- Work Hardening
- Injections *(including trigger points, facet blocks, epidural steroids, stellate ganglion blocks, BIER blocks)*
- Acupuncture
- Medications *(including anti-inflammatories, muscle relaxants, pain medications)*
- Hospitalization
- Surgery

Which treatment(s) provide(s) the most relief? _____

ORTHOPAEDIC CENTER OF SOUTH FLORIDA
600 SOUTH PINE ISLAND ROAD, SUITE 300
PLANTATION, FLORIDA 33324

ASSIGNMENT OF INSURANCE BENEFITS, POWER OF ATTORNEY AND RELEASE OF INFORMATION

Insurer Please Read the Following, in its Entirety, upon Receipt:

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the **benefits** of my No-Fault Policy of automobile insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above medical provider. This assignment of benefits includes over due interest payments and any potential claim for bad faith. I understand it is the express intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the medical provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the medical provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments made at the discretion of the insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e. to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider or any dispute. If the insurer schedules an IME or EUO the insurer is hereby requested and authorized to send a copy of said notification to this provider. The medical provider is not the agent of the insurer or the patient for any purpose.

I understand this assignment will remain in full force and effect and will not be revoked unless the revocation is agreed to by both the medical provider and the undersigned or the undersigned's attorney. The assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

Power of attorney: The above medical provider is hereby given the power of attorney by the undersigned to deposit any checks for payment for services rendered by the above provider.

Release of information: I hereby authorize this medical provider to: furnish the insurer and the patient's attorney with any and all information that may be contained in the medical records; to obtain coverage information telephonically from the insurer; to request all EOBs and non-redacted PIP payout sheets from the insurer; and to obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRIs from, any other medical provider or any insurer. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior written permission.

I certify that I have not been solicited or promised anything in exchange for receiving medical care or that I have received and promised or guarantees from anyone as to the results that may be obtained by any medical treatment.

Caution! Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the terms!

Patient's Name _____

Patient's Signature _____
(If patient is a minor, signature of parent/guardian)

Date _____

OCSF FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

The purpose of this form is to help our patient(s) understand Orthopaedic Center of South Florida, PA (OCSF) Financial Policy.

PAYMENT IS EXPECTED AT TIME OF SERVICE

OCSF accepts the following Types of Payments: Cash, Personal Checks, Major Credit Cards (i.e. American Express, Discover, MasterCard and Visa), and Care Credit with No interest for 6 months. There will be a \$25 fee for all returned checks.

All patients are required and responsible for the following:

- To bring any Referral and/or Authorization required by their health insurance, either Primary or Secondary, for services rendered;
- To provide OCSF with current home address and updated insurance;
- To pay for the co-payment, deductible and/or coinsurance at the time of service as designated by the insurance company;
- To pay for any previous balance at the time of service;

MEDICARE PATIENTS:

If patient is a Medicare member, patient will be responsible to review and sign the Medicare "ABN" Advanced Beneficiary Notice for services non-covered or not deemed Medically Necessary by Medicare, including orthotics, injections, etc. If patient has no secondary insurance, 20% coinsurance is required to be paid at time of service. The patient must notify OCSF if enrolled with any HMO/PPO.

MOTOR VEHICLE ACCIDENT PATIENTS:

If related to MVA accident, patient is to report accident to their own Automobile insurance within time limit and provide our office with the claim number. If patient does not have Automobile insurance, they need to report accident to the Automobile insurance in their household. If we file patient's health insurance, co-payment, deductible, and/or coinsurance is expected at the time of service.

WORKER'S COMP PATIENTS:

Patient will be treated for Worker's Comp. accident as long as we are the authorized treating physician(s). Once patient reaches MMI (Maximum Medical Improvement), patient shall be responsible for co-payment designated by Worker's Comp. If case is settled, we cannot file future claims to Worker's Comp., therefore, patient shall provide us with their health insurance information.

BILLING & COLLECTION PROCEDURES:

If eligible for Insurance benefits, it should be understood that the agreement is between the patient and their health insurance. Patient is responsible to pay for our services regardless of the status with their insurance company. Orthopaedic Center of South Florida, PA files claims promptly to the insurance company for services rendered as a courtesy to the patient. If there is a patient balance, statements are mailed monthly, around the 10th of every month, for a period not to exceed three (3) months. Any balance due beyond 30 days is subject to interest of 1.5%, which accumulates every month thereafter until balance is paid in full. OCSF may use an outside collection

agency in an attempt to collect any outstanding patient balance, and collection fees may be added.

OTHER ENTITIES:

During the course of your treatment, patient may be referred to other institutions for diagnostic testing, lab work, durable medical equipment and/or therapy. These Referrals are based solely on medical necessity and our affiliation with these institutions is based on providing our patients with the highest quality and professional medical care possible. Comments on patient's experience of these institutions will be used to modify and improve the Referral process. This notice will serve to advise our patient(s) that OCSF participates as a partner in the Centers listed below and that patient's signature acknowledges that he/she has been apprised of this information. The Centers are as follows:

- Coral Springs Surgical Center
- Memorial Same Day Surgery Center East
- Memorial Same Day Surgery Center West
- The Surgery Center of Ft Lauderdale

OCSF will make every attempt possible to refer our patient(s) to a facility participating with the patient's insurance plan; however, it is ultimately the patient's responsibility to find out if the facility is participating with their insurance company. OCSF will not be help responsible for any referral of a non-participating facility.

ASSIGNMENT OF BENEFITS:

The undersigned patient assigns the insurance benefits to Orthopaedic Center of South Florida, PA for services rendered. The medical provider agrees to accept the irrevocable assignment benefits for services rendered to the patient. A photocopy of this assignment is to be considered valid as an original.

DIRECTION TO PAY: The undersigned patient directs their Health Insurance to pay Orthopaedic Center of South Florida, PA directly for services rendered. In the event health insurance pays the patient directly, the patient agrees to endorse and turn payment over to Orthopaedic Center of South Florida immediately.

RELEASE OF INFORMATION: The undersigned patient authorizes Orthopaedic Center of South Florida, PA to furnish insurance and/or business associates with any and all information that may be necessary for treatment, for payment or for health care operations.

I certify that I have read, understand and agree to the terms and conditions indicated on this form. If Patient is under 18, I hereby give my permission and consent for patient to be treated by any physician part of Orthopaedic Center of South Florida, P.A.

Patient's Name

Patient's Signature (if minor, Parent or Guardian)

Date

Orthopaedic Center of South Florida
954-473-6344

Patient Acknowledgement & Receipt of Privacy Practices
YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have read and received a copy of the
Aforementioned practice's Notice of Privacy Practices.

Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other: _____

Orthopaedic Center of South Florida
954-473-6344

**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ **Social Security Number:** _____

Section B: To the Patient – Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use of your Protected Health Information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your Protected Health Information, and of other important matters regarding your Protected Health Information. A copy of our notice accompanies the consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our Protected Health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Robin Fielding, CEO

Address: 600 South Pine Island Road, Suite 300, Plantation, FL 33324

Telephone: (954) 473-6344 Fax: (954)476-9077

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect our action we took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by reading this consent form, I am giving my consent to your use and disclosure of my Protected Health Information to carry out treatments, payment activities and healthcare operations.

Signature: _____ **Date:** _____

Orthopaedic Center of South Florida
954-473-6344

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on April 15, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations; for example:

Treatment. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment. We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends. We must disclose your health information to you, as described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you what is reasonable and customary for Broward County for each page and hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice. If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Orthopaedic Center of South Florida, P.A.

Address: 600 South Pine Island Road, Suite 300, Plantation, Florida 33324

Telephone: (954) 473-6344 Fax: (954) 476-9077