PATIENT INFORMATION SHEET

Welcome to Cornerstone Orthopedics!

This form must be filled out completely to the best of your knowledge

I. Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security #: _____-_____-_____ Birth Date (Month/Day/Year): ____/____/_____ Sex: F M (Circle One)

Address: _____ Apt #:_____ City: _____

State: _____ Zip: _____/_____ Home phone: (_____) _____-_____

Work phone: (_____) _____-_____ ext.: _____ Cell phone: (_____) _____-_____

Email Address: _____ Occupation: _____

Employer: _____ Employer Phone Number: (_____) _____-_____

Emergency Contact Name: _____ Phone Number: (_____) _____-_____

Preferred Language: _____

Race: Please check one:
□ Native American Indian □ Asian □ Black/African American □ White/Caucasian □ Other □ More than one
□ Choose not to report

Ethnicity: Please check one: □ Hispanic or Latino □ Non-Hispanic □ Choose not to report

III. Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Is your injury work or auto related? If no, continue to section IV. If yes, (Circle One)

Workman's Comp Auto- State Accident Occurred_____

Claim #: _____ Date of Injury_____

Adjuster Name: _____ Adjuster Phone #: (_____) _____-_____ ext.: _____

Workerman's Comp Physician: _____ Phone # (____) _____-_____

IV. PRIMARY Policy Holder (Guarantor)

(For insurance billing purposes, we require the name, date of birth, address if different than the patient and employer name and phone number of the **person who is considered the insured**. This person is not always the patient and could be a spouse, parent or another person).

Guarantor Last Name: _____ First Name: _____ Middle Initial: _____

Guarantor Sex: F M (Circle One) Relationship to patient: _____

Address (if different from patient): _____ Apt #: _____

City: _____ State: _____ Zip: _____

Guarantor Phone Number: (_____) _____-_____ Guarantor Date of Birth: _____/_____/_____

Guarantor Social Security # : _____-_____-_____ Guarantor Employer Name:_____

Employer Phone Number: (_____) _____-_____

V. SECONDARY Policy Holder (Guarantor) – If Applicable

(For insurance billing purposes, we require the name, date of birth, address if different than the patient and employer name and phone number of the **person who is considered the insured**. This person is not always the patient and could be a spouse, parent or another person).

Guarantor Last Name: _____ First Name: _____ Middle Initial: _____

Guarantor Sex: F M (Circle One) Relationship to patient: _____

Address (if different from patient): _____ Apt #: _____

City: _____ State: _____ Zip: _____

Guarantor Phone Number: (_____) _____-_____ Guarantor Date of Birth: _____/_____/_____

Guarantor Social Security #: _____-_____-_____ Guarantor Employer Name: _____

Employer Phone Number: (_____) _____-_____

Authorization to Pay Benefits/Release Information

I hereby authorize payment directly to the Physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay for all non-covered services. I also hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Print Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____
(If patient is under 18, the parent or guardian must sign)

ORTHOPEDIC CENTERS OF COLORADO

PATIENT INTAKE AND HISTORY FORM

Today's Date: _____

Name:_____ **Date of Birth:**_____ **Age:**_____
Primary Care Physician:_____ **Tel:**_____
Primary Care Physician City:_____ **ZIP:**_____
Referral Source:_____ **Tel:** _____

Have you been treated at any Orthopedic Centers of Colorado division in the last 3 years?

__Advanced Orthopedic __Cornerstone Orthopaedics __Orthopedic Associates
__CCOE __Denver Spine Specialists __Peak Orthopedics
__Colorado Orthopedic Consultants __Hand Surgery Associates

Local Pharmacy: Name: City: Phone:

Mail Order Pharmacy: Name: City: Phone:

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Hand Dominance: ___Left Hand ___Right Hand ___Ambidextrous **Shoe Size:** __N/A_____

How did the problem start? ___Gradual ___Suddenly ___Exacerbation of an old injury/issue

When did the problem start? ___hour(s) ago ___day(s) ago ___week(s) ago ___month(s) ago

Where did the injury take place? ___at home ___at work ___at school ___while playing sports ___while playing ___during recreational activities ___in a motor vehicle accident

Please describe the progression of the problem: __unchanged __fluctuating __resolved __stable __improving __worsening

Describe the severity of the symptoms/pain: __mild __mild to moderate __moderate __moderate to severe __interfering with sleep __incapacitating

How would you describe your pain? __aching __a dull ache __a deep ache __shooting __a burning sensation __throbbing __superficial __a discomfort __stabbing __cramping __sharp

How often does your pain occur? __intermittently __occasionally __frequently __constantly __rarely __during the day __nocturnally

What makes your condition feel worse?_____
What makes your condition feel better?_____
Have you seen another physician for this issue? __No __Yes, who and when?_____

What treatments have you tried in the past? None

__Application of ice __Application of heat __Physical Therapy __Exercise __Activity Modification __Brace
__NSAIDS __Other Medication __Injections __Acupuncture __Chiropractic care __Surgical Treatment
__Massage __Dry Needling __Non-Surgical Treatment __TENS Unit

ALLERGY HISTORY:

___None **___NKDA (No Known Drug Allergies)**

Metal Allergies:	__No	__Yes	Agent:_____	Reaction: _____
Latex Allergies:	__No	__Yes	Agent:_____	Reaction: _____
Cement Allergies:	__No	__Yes	Agent:_____	Reaction: _____
Medication Allergies:	__No	__Yes	Agent:_____	Reaction:_____
			Agent:_____	Reaction:_____
			Agent:_____	Reaction: _____
			Agent:_____	Reaction: _____

Other Allergies: __No __Yes Agent:_____ Reaction:_____
Agent:_____ Reaction:_____
Agent:_____ Reaction: _____

MEDICATION HISTORY:

____ I am not currently taking any medications

____ I am taking medications, vitamins, minerals, supplements, and /or alternative/herbal medications. Please list all items on the attached medication sheet.

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___Alzheimer Disease
___Anemia
___Arthritis
___Asthma
___Blood Clots/DVT
___Cancer:_____
___Chest Pains
___Congestive Heart Failure
___COPD
___Coronary Disease
___Crohn's Disease
___Degenerative Disc Disease
___Depression
___Diabetes
___Drug Abuse
___Fibromyalgia
___Fracture
___Gout
___Headache
___Heart Disease
___Heart Murmur
___High Blood Pressure
___High Cholesterol
___IBS
___Liver Disease
___Lupus
___Lyme Disease
___Heart Attack (MI)
___Obesity
___Osteoporosis
___Parkinson Disease
___Peptic Ulcer
___Psoriasis
___Scoliosis
___Seizures
___Sleep Apnea
___Spinal Stenosis
___Spondyloarthropathy
___Stroke
___Thyroid Disease
___Vascular Disease
___Brain Injury
___Multiple Sclerosis

___Peripheral Neuropathy Other: _____

Do you have any of the following:

___History of Joint Infection? **___History of Benign Tumor?** **___History of Cancer?**

If yes, please give detailed information, including body location and time period:

_____
_____
_____

FAMILY HISTORY:

Place an "X" under the correct family member with the condition and indicate "P" if the family member passed away due to that condition.

	Mother	Father	Sibling
Alcohol Abuse			
Anemia			
Arthritis			
Anesthetic Complications			
Anxiety			
Asthma			
Birth Defects			
Blood Disorder			
Cancer: type:			
Depression			
Diabetes Type I			
Diabetes Type II			
Genetic Disease			

	Mother	Father	Sibling
Gout			
Heart Disease			
Hypertension			
High Cholesterol			
Kidney Disease			
Lung/Resp Disease			
Migraines			
Osteoporosis			
Seizure Disorder			
Severe Allergies			
Stroke			
Substance Abuse			
Thyroid Problems			

Other:_____

PAST SURGICAL HISTORY

____**None** (Please mark as applicable, date does not need to be exact)

Procedure	Year	Procedure	Year	Procedure	Year
__ACL Repair – Left	_____	__Cardiac Bypass Surgery	_____	__Knee Replacement – Lt	_____
__ACL Repair – Right	_____	__Cardiac Pacemaker Insertion	_____	__Knee Replacement – Rt	_____
__Amputation	_____	__Cardiac Valve Replacement	_____	__Meniscus – Left	_____
__Angioplasty	_____	__Carpal Tunnel Surgery – Lt	_____	__Meniscus – Right	_____
__Appendectomy	_____	__Carpal Tunnel Surgery – Rt	_____	__Neck Surgery	_____
__Arthroscopic Ankle – Left	_____	__Cataract Surgery	_____	__ORIF Fracture – Left	_____
__Arthroscopic Ankle – Right	_____	__Cholecystectomy/Gallbladder	_____	__ORIF Fracture – Right	_____
__Arthroscopic Knee – Left	_____	__Colectomy	_____	__Rotator Cuff Repair – Lt	_____
__Arthroscopic Knee – Right	_____	__Colostomy	_____	__Rotator Cuff Repair – Rt	_____
__Arthroscopic Shoulder – Lt	_____	__Gastric Bypass	_____	__Small Bowel	_____
__Arthroscopic Shoulder – Rt	_____	__Hernia Repair	_____	__Thyroidectomy	_____
__Back Surgery	_____	__Hip Replacement – Lt	_____	__Orthopedic:	_____
__Blood Transfusion	_____	__Hip Replacement – Rt	_____	__C-Section	_____

Other:_____

_____

_____

Have you experienced any adverse events associated with surgery or anesthesia?

☐ **No** ☐ **Yes, if so, please give pertinent details:** _____

_____

Have you had imaging for this problem? YES NO (XRAYS MRI CT OTHER:_____)

If so, where and when?_____

Have you had an EMG? YES NO Where:_____When:_____

Have you had Pain Injections? YES NO Where:_____When:_____

What type:_____

SOCIAL HISTORY:

Please describe your current tobacco/marijuana use habits:

__Never __Former (I quit_____years ago)

I use: __Cigarettes __Vaping __Marijuana __Marijuana Edibles __Chew/Dip

Frequency __Current every day __Light Occasional __Heavy

Do you drink alcoholic beverages? __Yes __No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? __Yes __No

If yes, please indicate what type of drug and how often: _____

How would you rate your exercise level? __Sedentary __Mild __Moderate __Vigorous

REVIEW OF SYSTEMS

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them.

General: __Normal
- ❑ Fatigue
- ❑ Chills

Cardiovascular: __Normal
- ❑ Chest Pain
- ❑ Fainting
- ❑ Dizziness
- ❑ Murmur

Psychiatric: __Normal
- ❑ Anxiety
- ❑ Depression
- ❑ Drug/Alcohol Abuse

Endocrine/Glands: __Normal
- ❑ Unexplained Weight Loss
- ❑ Unexplained Weight Gain
- ❑ Fever
- ❑ Thyroid Problems
- ❑ Diabetes

Skin: __Normal
- ❑ Blisters
- ❑ Rash
- ❑ Infection or history of MRSA
- ❑ Ulcer

Hematology: __Normal
- ❑ Anemia
- ❑ Easy Bleeding
- ❑ Blood Clots

HEENT: __Normal
- ❑ Blurred Vision
- ❑ Vision Loss
- ❑ Difficulty Swallowing
- ❑ Hearing Loss

Neurological: __Normal
- ❑ Headaches
- ❑ Numbness
- ❑ Dizziness
- ❑ Frequent Falls
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness
- ❑ Tremors
- ❑ Unsteadiness
- ❑ Memory Loss
- ❑ Concussion

MSK: __Normal
- ❑ Negative except noted in reason for visit
- ❑ Arthritis_____
- ❑ Osteoporosis
- ❑ Carpal Tunnel

Respiratory: __Normal
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Difficulty Breathing
- ❑ Recent Respiratory Infection
- ❑ Sleep Apnea

Today's Date: Name: DOB: Age:

Height _____ft _____inches Weight_____

Have you had your flu shot for the 2020-2021 season? Date: _____

Have you had a Pneumococcal Vaccination? No_____ Yes/Date Received: _____

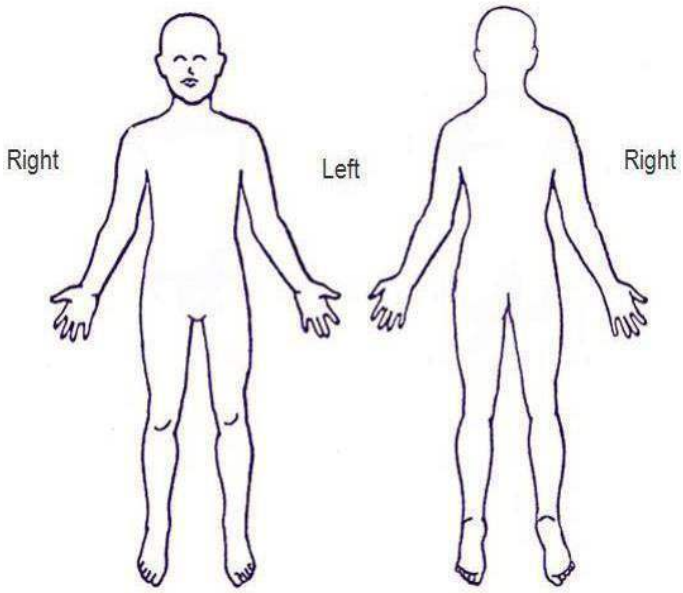
Have you had a fall in the last year?

- If yes, how many falls? _____
- Did the fall result in injury? If yes, please list details
  _____

FOR SPINE PATIENTS ONLY:

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

Sharp/Stabbing Pain (xxx)	Numbness (---)	Pins and Needles (***)
Dull Ache (000)	Burning (///)	Weakness (+++)



CORNERSTONE
Orthopaedics & Sports Medicine, P.C.

Patient Medication Form

Please list all current Medications, Vitamins, and Supplements

Patient Name _____ DOB:_____

Medication Name	Dosage	Frequency	Route

Please use additional pages as needed

CORNERSTONE ORTHOPEDICS & SPORTS MEDICINE

Consent to Leave Phone/Email/Fax Messages

At times, we may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed the following policy on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave detailed messages on voice mail or answering machines
- We will NOT send emails/faxes

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ give my permission for Cornerstone Orthopedics to leave phone messages and/or email/fax messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient Name: _____

Date of Birth: _____

How would you prefer to receive normal test results?

□ Email Email Address: _____

□ Fax Fax Number: _____

□ Phone Phone Number: _____

May we leave a phone message to inform you that test results are available, give appointment reminders or with billing questions and to contact our office for more information? Please indicate the appropriate phone number below.

Home Phone: _____ □ Yes □ No

Work Phone: _____ □ Yes □ No

Cell Phone: _____ □ Yes □ No

Who else may we share your test results with on your behalf?

Spouse/Partner: □ Yes □ No If yes, name: _____

Son/Daughter: □ Yes □ No If yes, name: _____

Other: □ Yes □ No If yes, name: _____

Special Instructions, if any: _____

_____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

CORNERSTONE ORTHOPAEDICS
& SPORTS MEDICINE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 4/1/2003 Revised: 9/01/2013

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose, treat, or provide you with a service.

  Cornerstone is a member of a community of practices (Integrated Physician Network - iPN) that use a common medical record to make your healthcare safer, more efficient and of the highest quality. Your health information may be shared electronically within this network with other physicians, providers and practices but only if they are participating in your care.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. For example, we may give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations, e.g., to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information.
- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services, e.g. transcription. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank.
- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Military and Veterans.** If you are a member of the armed forces or foreign military, we may disclose Protected Health Information as required by the appropriate military command authorities.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities, e.g., for purposes related to the quality, safety or effectiveness of an FDA-regulated product; to prevent or control disease, injury or disability; or to notify people of recalls of products they may be using.
- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law e.g., audits, investigations, licensure, and similar activities.
- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order, subpoena or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to

our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. **Louisville office patients: We cannot amend information in your medical record entered by another practice in the iPN (please ask for list of iPN practices if your are uncertain).** In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. **Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full.** If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. **You must make any such request in writing and you must specify how or where we are to contact you**. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Signature below is to acknowledge that you have received Cornerstone Orthopaedics Notice of Privacy Practices:

Signature:_____ Date:_____

Print Name:_____

Relationship to Patient _____Self _____Parent _____ Legal Guardian

Patient Name (if different from above) _____

Patient Date of Birth: _____

CORNERSTONE
Orthopaedics & Sports Medicine

Patient Financial Responsibility Policy

Cornerstone Orthopaedics & Sports Medicine's financial policy enables us to provide quality, cost effective health care, therefore, we request you review the following procedures and acknowledge your acceptance by providing your signature below.

FEES: Charges for our services are based on what is usual and customary for the severity and complexity of your problem.

BILLING & PAYMENT: Payment is due at the time of service for each office visit. If you have insurance your co-pay, deductible, and cost of non-covered services is due prior to each visit. We accept cash, check, MasterCard, Visa, American Express and Discover.

If you are unable to make your co-payment for a particular visit, we will be happy to re-schedule your appointment at the earliest convenient date.

If you do not have insurance, we require proof of method of payment prior to being seen and payment at the end of each visit.

INSURANCE: If your insurance requires a pre-authorization (referral) from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. As a courtesy, we will submit your bill with us to your insurance company; however, payment for your services is your responsibility. If your insurance company does not pay your bill within 60 days, you will receive a statement from Cornerstone showing the status of your account. Should you receive this statement, you will need to contact your insurance company to determine status of the payment.

If your claim is not paid by the insurance company within 90 days of the date of service, Cornerstone will hold you personally responsible for full payment of the balance.

NON-INSURED PATIENTS: Cornerstone Orthopaedics strives to avoid barriers to treatment; therefore, we have a financial counselor available that will be happy to work with you concerning options for payment.

WORKER'S COMPENSATION: We will need your Workers' Compensation claim number and insurance carrier's address to bill your insurance company. If this information is not available by the time of your appointment, we will need to either re-schedule your appointment, submit the charges to your private insurance, or you may personally pay at the time of service. If the worker's comp insurance or your employer denies your injury was an on-the-job injury, Cornerstone will hold you personally responsible for full payment of the balance due.

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FORMS: The first copy of disability/FMLA and other employer-provided forms will be provided for free; any additional forms will be provided for a $25 prepayment.

XRAYS & MRIs: A digital copy of your X-rays or MRI will be provided for a payment of $5. Film x-rays cannot be duplicated; original film x-rays can be checked out at no charge but we cannot accept any responsibility for lost or damaged films once they are checked out. Please allow 72 hours for copy requests to be processed.

DME: During the course of your orthopedic care, you may receive supplies from our office such as a knee brace, walking boot, shoulder sling, wrist splint or an ankle sleeve to assist in treating your problem/injury. Insurance companies label such supplies as Durable Medical Equipment, or DME.

Unfortunately, DME products may not be considered a covered benefit under certain insurance plans. Because all insurance plans are different, Cornerstone Orthopedics will first bill your insurance for the DME you may receive from us. In the event these items are not covered by your insurance plan, we will then bill you directly for the cost of these items.

Therefore, we ask that you acknowledge your understanding to your insurance company that DME received at Cornerstone may be covered in part, in full or denied in full by signing the following statement:

> I understand that Cornerstone Orthopedics will bill my insurance for the DME that I may receive during my treatment. I understand that in the event my insurance company denies payment for the DME, Cornerstone will bill me directly and I will be financially responsible for any unpaid balance.

Thank you for reviewing our financial policy. We look forward to serving you.

I have read the above policy and agree to comply with its contents.

_____ _____

Signature (if patient is under 18 years, guarantor or parent signature is required) Date

_____ _____

Print Patient Name Date of Birth