ORTHOPAEDIC SURGERY SPECIALISTS

ossburbank.com

WELCOME

2625 Alameda Avenue • Suite 116 • Burbank, CA 91505-4870 • Phone (818) 841 - 3936 • Fax (818) 841-5974

Welcome to Orthopaedic Surgery Specialists. We look forward to helping you. Below is checklist to ensure that you are prepared for your appointment. We will do our best to maintain your scheduled time.

Please complete this paperwork and bring with you to your appointment. When you come for your appointment:

- Please arrive 10-15 minutes early to complete any additional required paperwork not included in this packet (I.e. Arbitration).
- Bring any tests (X-rays, CT Scans, MRI's) relevant to your problem. It is important to bring the actual films or CD of the studies, as well as, the reports.
- Bring a complete and accurate list of your current medications (prescription and over the counter).
- Bring your valid health insurance card and your photo ID.
- Please be prepared to make payment for any co-payments, co-insurances, deposits and/or deductibles.
- Please bring your referring doctor's contact information

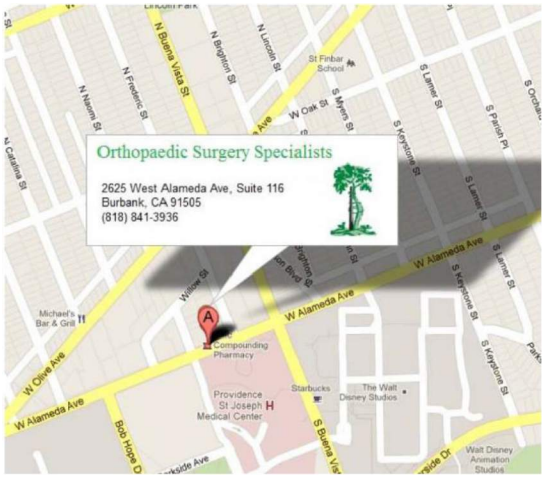
1. Please dress in a way that will allow our providers to best evaluate your injury (shorts for hip and leg injuries, tank tops/t-shirts for Shoulder and arm injuries). Gowns will be made available if needed.

2. If you need to cancel or reschedule your appointment, please give us at least 24 hours notice so that we can offer your appointment time to another patient.

3. Our contact information:

2625 West Alameda Avenue
Suite 116 (First Floor)
Burbank, California 91505
Telephone (818) 841-3936

Parking is available in the parking structure adjacent to the office building. Parking fees do apply. We do not validate. Alternatively, there is street parking available.



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OFFICE POLICIES

Orthopaedic Surgery Specialists prides itself on one-on-one, personalized patient care. To keep our commitment to excellent service, we ask that you review our policies. ***Kindly sign and date to confirm you understand and will follow our practice's policies.***

FINANCIAL POLICY

We appreciate your business and we want to thank you for being responsible in managing the financial element of your care. If you have any questions based on the information below, please discuss them with our staff before you see our doctors.

Our doctors are contracted with many Preferred Provider Organization (PPO) health insurance plans. We accept patients who are "In Network" and "Out of Network." Note: Even if your health plan indicates that you have "out of network" benefits, please consult our staff so we can verify your authorized benefits. We welcome Medicare, Worker's Compensation plans, and patients who pay by cash (self-pay).

- We accept cash, check, Visa and MasterCard.
- The adult accompanying a minor is responsible for payment of all services rendered to minor patients.
- Please update our staff with a change of address and/or telephone number anytime a change occurs.

If you have a health plan that we accept, please:

- Present your health plan card and proof of identity (e.g. driver's license) at each visit. Note: Some health plans issue a pharmacy card too. We only accept your medical health plan card.
- Update our staff with a change of insurance **anytime** a change occurs.
- Expect that we will bill your health plan IF YOU ARE covered by one of these plans that we accept. Be prepared to pay the co-payment or co-insurance at the time of service. When we contract with insurance companies, these agreements state we can't charge you (the patient) other than co-pays, deductibles and items deemed by the carrier as billable charges to the patient. If we later receive a check from the insurer, we will refund any overpayment to you.
- A prepayment of your deductible and co-insurance will be required for your portion of our fees, based on our contracted allowable rate, for scheduled surgical procedures. Any balance remaining, after your health insurer pays, is your responsibility. Payment is due upon receipt of a statement from our office.
- Respond promptly to your insurance company to provide any information that it may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming overdue and payable, in full, immediately.
- Be aware that all health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. We recommend you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.
- When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, etc., the fee not only includes the service on the day it is performed, but includes routine followup care as well. The global period ranges from 10-90 days depending on the procedure and your health plan. Xrays and supplies (such as casting or dressing materials, splints, braces, etc) are not included in the global fee and a charge will be made for these items. Services related to complications are not included in the global fee.
- **Out of Network:** We will bill your insurance company. Insurance companies typically pay out-of network fees directly to the insured. If your insurance company pays our office directly and the total amount paid (out-ofpocket + insurance payment) is more than the amount billed, you will receive a refund within 30 days of payment.

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Fracture Care (Broken Bones):

- Health plans have created a series of numeric codes to be used by doctors when treating patients. Insurance companies mandate that your doctor use these codes. There are special codes for patients with fractures.
- If you are being treated for a fracture you may encounter these "codes" on your Explanation of Benefits statement (EOB). They may often times be referred to as "office surgery" or "office procedure." Many patients are alarmed when they see "surgery" on their bill, when they know that they have not had surgery. This is simply how your insurance company has elected to process and label insurance claims.
- Fracture care codes have a 90-day global period. A 90-day global period is a period of 90-days after a procedure (surgery or initial visit for fracture care) which entitles you to 90-days of follow up care. This means that your physician is paid only the first time they see you for your fracture (broken bone). This fee covers your care for the next 90-days. Moreover, this fee does NOT cover any repeat X-rays, supplies (braces, casts), or new complaints. These are billed separately.
- Often times your physician will examine you, interpret your X-rays, consider different treatment plans, and determine which is best for you. This may involve a manipulation of the fracture (bone setting) with possible splinting or casting, and careful continued observation. Whatever the treatment rendered, the fracture care code will cover the costs of all your follow up visits for 90-days (excluding repeat X-rays casts/splints).

I have read and I understand the above Financial Policy and I agree to abide by its terms.

Signature of Patient or Responsible Party: _____ Date: _____

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ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my insurance carrier, including Medicare, to pay directly to my physician, Orthopaedic Surgery Specialists & Affiliated Associate, for services rendered for me. I hereby authorize my physician to release information from my medical records necessary to bill my insurance carrier for these services. A photocopy of my signature on this form is to be considered as valid as the original.

Patient or Insured Name (print): _____

Signature: _____ Date: _____

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NARCOTIC (PAIN) PRESCRIPTION POLICY

Our doctors prescribe Narcotic Medications only in cases of acute injury and after surgery for a period of no more than 6 weeks. If you require long term pain control, you will be referred to your primary care physician or to a pain management specialist.

Our office requires 48 hours to process narcotic prescription refills. Please contact us or your pharmacy so you will not run out of medication while waiting for your prescription to be processed. ***Prescriptions will only be refilled between*** 8:30 AM - 4:30 PM, Monday through Friday.

I have read and I understand the above Narcotic (Pain) Prescription Policy and I agree to abide by its terms.

Signature of Patient or Responsible Party: _____ Date: _____

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PATIENT PERSONAL FORM

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GENERAL

Patient Name Last Name First Name M.I.			Today's Date (MM/DD/YYYY)
Social Security Number	Driver's License Number and State Issued	Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)
Email Address		Name of Spouse / Partner	
Home Address *Number* *Street* *City* *State* *Zip*			
Primary Telephone (Best # to reach you) ☐ Cell ☐ Home ☐ Work		Secondary Telephone ☐ Cell ☐ Home ☐ Work	
Emergency Contact	Relationship	Home Telephone	Secondary Telephone ☐ Cell ☐ Home ☐ Work

EMPLOYMENT

Employer		Job Title	
Employer Address *Number* *Street* *City* *State* *Zip*			
Is this a work related injury? ☐ Yes ☐ No	Claim #	Claim Adjuster and Telephone	Case Manager and Telephone
If yes, has your employer been notified? ☐ Yes ☐ No			

LEGAL

Is there a legal case or lawsuit involved with this injury? ☐ Yes ☐ No	Attorney or Liability Representative Name and Telephone
Is an attorney, liability carrier, or auto insurance involved in payment? ☐ Yes ☐ No	

MEDICAL REFERRALS

Who referred you to our practice?

Name: ☐ Doctor ☐ Relative ☐ Friend ☐ Insurance Company ☐ Hospital ☐ Internet

PRIMARY INSURANCE

Insurance Company Name		I.D./Policy Number	Group Number
Insured Name		Insured Social Security #	Insured Date of Birth (MM/DD/YYYY)
Subscriber of the Health Insurance	Relationship to Insured	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

SECONDARY INSURANCE

Insurance Company Name		I.D. / Policy Number	Group Number
Insured Name		Insured Social Security #	Insured Date of Birth (MM/DD/YYYY)
Subscriber of the Health Insurance	Relationship to Insured	Subscriber Social Security #	Subscriber Date of Birth (MM/DD/YYYY)

AUTHORIZATION

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize examination and all services deemed medically necessary. I authorize the release of all medical information necessary to process my claim. I agree to assume financial responsibility for ALL services provided.

X

Signature of Patient or Responsible Party *Date*

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MEDICAL QUESTIONNAIRE

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GENERAL

Name *Last Name* *First Name* *M.I.*				Today's Date (MM/DD/YYYY) / /
Gender ☐ Male ☐ Female	Height	Weight	Age	Which is your dominant hand? ☐ Left ☐ Right
Referring Doctor & Phone			Primary Care Doctor & Phone	

Have you been discharged from an inpatient facility in the past 30 days? If yes:

What was your date of discharge?

Were any of your medications changed?

CURRENT PROBLEM

What part of your body are you being seen for today? Which side? (if applicable) ☐ Left ☐ Right

What is the goal of your appointment today?

☐ Pain Management ☐ Better Function ☐ Better Appearance ☐ Return to Work ☐ Return to Play ☐ Other: _____

How did the problem develop?

When did the problem start: ☐ Over Time (Duration:_____) ☐ Injury (Date of Injury: _____)

Is this work related? ☐ Yes ☐ No

On a scale of 0-10 (0=no pain, 10= worst possible pain) what is your level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: ☐ Numbness? ☐ Tingling? If yes, where:

Have you noticed any weakenss? ☐ Yes ☐ No If yes, explain:

What other symptoms do you have?

Do your symptoms limit your ability to work? ☐ Yes ☐ No If yes, explain:

Do your symptoms affect your activities of daily living? ☐ Yes ☐ No If yes, explain:

Do your symptoms keep you awake at night? ☐ Yes ☐ No

What treatments have you tried? ☐ Injection ☐ Physical Therapy ☐ Chiropractic ☐ Medication:_____ ☐ Other: _____

Have any treatments helped? ☐ Yes ☐ No Please explain:

How many street blocks can you walk?

Do you use a walking device? ☐ Cane ☐ Crutches ☐ Walker ☐ Wheel Chair ☐ Not Applicable; Don't use a walking device

Describe how you use stairs: ☐ Place one foot per step ☐ Place both feet on step before proceeding to next ☐ Not Applicable; Don't use stairs

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MEDICAL QUESTIONNAIRE

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MEDICAL HISTORY: LIST ALL

Medical problems:

Medications:

Supplements:

Surgeries:

Drug allergies (include reaction):

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed **Name:**

Hobbies / Interests: **Occupation:**

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If "Yes": How often did you have a drink containing alcohol in the past year?

☐ Never (0 point) ☐ Monthly or less (1 point) ☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points) ☐ 4 or more times a week (4 points)

If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point) ☐ 3 or 4 drinks (1 point) ☐ 5 or 6 drinks (2 points)

☐ 7 to 9 drinks (3 points) ☐ 10 or more drinks (4 points)

If "Yes": How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 point) ☐ Less than monthly (1 point) ☐ Monthly (2 points)

☐ WeekIt (3 points) ☐ Daily or almost daily (4 points)

Do you use tobacco products? ☐ No ☐ Yes **If yes, how many packs per day?**

Do you use recreational drugs? ☐ No ☐ Yes **Describe:**

IF YOU ARE 65 OR OLDER

Do you have an advance care plan or surrogate decision maker?

Have you fallen in the last 12 months? ☐ No ☐ Yes **If "Yes": How many times?** **Were you injured?**

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print) _____ **Signature**_____ **Date**____/____/____

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HEALTH REVIEW (Do you have any of the following?)

GENERAL			***GASTROINTESTINAL***		
Have you been in good general health most of your life	☐ No	☐ Yes	Vomiting blood or food	☐ No	☐ Yes
Any allergies, including medication	☐ No	☐ Yes	Gallbladder disease	☐ No	☐ Yes
Any recent weight gain	☐ No	☐ Yes	Liver trouble	☐ No	☐ Yes
SKIN			Hepatitis	☐ No	☐ Yes
Skin Disease	☐ No	☐ Yes	Painful bowel movements	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes	Black stools	☐ No	☐ Yes
Hives, eczema or rash	☐ No	☐ Yes	Hemorrhoids or piles	☐ No	☐ Yes
Frequent infections or boils	☐ No	☐ Yes	Recent changes in bowel habits	☐ No	☐ Yes
Abnormal pigmentation	☐ No	☐ Yes	Heartburn or indigestion	☐ No	☐ Yes
HEAD, EYES, EARS, NOSE, THROAT			***GENITOURINARY***		
Eye diseases or injury	☐ No	☐ Yes	Loss of urine	☐ No	☐ Yes
Wear glasses	☐ No	☐ Yes	Frequent urination	☐ No	☐ Yes
Double vision	☐ No	☐ Yes	Night time urinating	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Blood in urine	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes	Kidney trouble / Kidney stones	☐ No	☐ Yes
Itching eyes or nose	☐ No	☐ Yes	***LOCOMOTOR - MUSCULOSKELETAL***		
Sneezing or runny nose	☐ No	☐ Yes	Osteoporosis	☐ No	☐ Yes
Nosebleeds	☐ No	☐ Yes	Varicose veins	☐ No	☐ Yes
Chronic sinus trouble	☐ No	☐ Yes	Weakness of muscles or joints	☐ No	☐ Yes
Ear disease	☐ No	☐ Yes	Difficulty walking	☐ No	☐ Yes
Impaired hearing	☐ No	☐ Yes	Pain in calves or buttocks on walking, relieved by rest	☐ No	☐ Yes
Dizziness or transient episodes of unconsciousness	☐ No	☐ Yes	***NEURO - PSYCHIATRIC***		
RESPIRATORY			Ever had psychiatric care	☐ No	☐ Yes
URI (cold) now	☐ No	☐ Yes	Ever been advised to see a psychiatrist	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes	Fainting spells	☐ No	☐ Yes
Chronic of frequent cough	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes	Paralysis	☐ No	☐ Yes
Difficulty breathing	☐ No	☐ Yes	***ENDOCRINE***		
CARDIOVASCULAR			Diabetes	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes	Thyroid disease	☐ No	☐ Yes
Shortness of breath with walking or lying down	☐ No	☐ Yes	Hormone therapy	☐ No	☐ Yes
Heart trouble or heart attacks	☐ No	☐ Yes	Any change in hat or glove size	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Any change in hair growth	☐ No	☐ Yes
Swelling of hands, feet or ankles	☐ No	☐ Yes	Become colder than before or skin become dryer	☐ No	☐ Yes
Heart murmur	☐ No	☐ Yes	***HEMATOLOGICAL***		
NECK			Slow to heal after cuts	☐ No	☐ Yes
Stiffness	☐ No	☐ Yes	Blood disease	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes	Anemia	☐ No	☐ Yes
			History of blood clots	☐ No	☐ Yes
			Bleeding problems	☐ No	☐ Yes

FAMILY'S HEALTH REVIEW (Has any blood relative ever had any of the following?)

Cancer	☐ No	☐ Yes	Convulsions	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes	Suicide	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Mental illness	☐ No	☐ Yes
Heart trouble	☐ No	☐ Yes	Bleeding tendency	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes	Gout or other arthritis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Hereditary defects	☐ No	☐ Yes

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name (print)_____ **Signature**_____ **Date**____/____/____

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NOTICE OF PRIVACY PRACTICES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 1996 (HIPAA)

ORTHOPAEDIC SURGERY SPECIALISTS

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

This notice takes effect on January 1, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies on a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $ .25 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations an other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

A COPY OF THIS FORM IS AVAILABLE FOR YOU UPON REQUEST FROM RECEPTIONIST.

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also 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. We will not retaliate in any way if you choose to file a complaint.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical 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 share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

STEPHAN V. YACOUBIAN, M.D. • RAYMOND B. RAVEN III, M.D. • SHAHAN V. YACOUBIAN, M.D. • YURI FALKINSTEIN, M.D.
2625 W. Alameda #116 • Burbank, CA 91505 • Phone (818) 841-3936 • Fax (818) 841-5974
Privacy Officer: Susan Swindell

HIPAA PRIVACY PREFERENCES

Please select the level of privacy you would like Orthopaedic Surgery Specialists (OSS) to observe concerning your information (appointment information, test results, procedure results, etc.)

☐ OSS may only discuss my information with me, directly.

If we are not able to reach you directly, may we provide you with your information via messages?

☐ OSS may leave voice messages containing my information at the following phone number(s):

_____ (home) _____ (cell) _____ (work) _____ (other)

☐ OSS may send unencrypted emails from the physician and his staff to the following e-mail address:

_____
(e-mail address)

Is there anybody else that you would like to allow us to speak to about your information if they inquire about you? This should be anyone (family member, friend, caretaker, etc.) that might ever come into an appointment with you, help you with your forms, call to make or check on an appointment for you, or pick anything up for you from our office. **If someone does come to us on your behalf but their name is not listed below, we will not be able to share anything with them regarding any of your information.**

☐ OSS may share my information with the following individuals:

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

Those listed above **must answer the following security question before any information is shared:

What is the patient's birthday? _____

Under the requirements of HIPAA we are not allowed to give information to anyone other than the patient without the patient's written consent. Signing this form will only give consent to release appointment information, test results, and procedure results to the designated person(s) above. This consent form will not allow the doctor to release any other information to this person. You may revoke this consent in writing except where we have already made disclosures on your prior consent.

_____ (print patient's name) _____ (sign patient's name) _____ (date)

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Susan Swindell
Practice Manager

Dear Patient,

We would like to have the name, address, and phone number of your chosen pharmacy so your doctor can eprescribe when necessary. Thank you.

Patient: _____

Pharmacy: _____

Address: _____

_____

Phone: _____