ORTHOPAEDIC & SPORTS
MEDICINE CENTER OF MIAMI

ORTHOPAEDIC & SPORTS MEDICINE CENTER OF MIAMI, P.A.

PATIENT INFORMATION

Patient Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work Phone: _____ Ext. _____

Please Circle: Male Female Please Circle: Married Single Widowed

Date of Birth: _____ Social Security# _____ E-mail: _____

Is this an accident related injury? Yes No Did this accident happen at: Home Work Auto School Other

Date of Accident _____ Description of Accident: _____

_____

Were you treated at an emergency facility? Yes No

Which facility: _____ Treating Physician: _____

Were X-rays or other tests done? Yes No Please Describe: _____

Personal or Primary Care Physician Name _____

Whom referred you to our office? _____

Patients Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

IF THE PATIENT IS A MINOR THIS SECTION MUST BE COMPLETED BY ACCOMPANIED GUARDIAN

Mothers Name: _____ SSN: _____ DOB: _____

Fathers Name: _____ SSN: _____ DOB: _____

Insurance Information: (PLEASE PRESENT YOUR ID CARD TO THE FRONT RECEPTIONIST)

1- Insurance Company Name: _____ ID: _____

Insured Name: _____ DOB: _____ Group: _____

Authorization: _____ Visits: _____ Expires: _____

#2- Insurance Company Name: _____ ID: _____

Insured Name: _____ DOB: _____ Group: _____

Authorization: _____ Visits: _____ Expires: _____

I hereby authorize payment directly to Orthopaedic & Sport Medicine Center of Miami, P.A. and/or Daniel G. Kalbac, M.D. for benefits due to me from my insurance company payable to me. I further authorize the release of any medical information required by my insurance carriers. A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefit either to myself or to the party who accepts assignment I understand that I am financially responsible for charges not covered by this authorization.

I acknowledge receipt of the HIPAA – Summary of Notice of Privacy Practices of Orthopaedic & Sport Medicine Center of Miami, P.A. and have signed the Acknowledgement of Receipt

I hereby understand and receive Summary of Notice and HIPAA compliance. Initial: _____

Signature: _____ Date: _____

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Addendum to Patient Information

Notification

I hereby accept to the standards and policy of Orthopaedic & Sports Medicine Center of Miami regarding the No Show and Cancellation fee.

I will be charged the mount of $25.00 for any appointments not cancelled within 24 hours prior to my scheduled time. I also understand appointment cancellations must be called in during the regular business hours Monday thru Friday from 8:30 AM to 5:00 PM.

If scheduled on Monday, my appointment must be cancelled no later than Friday to prevent being charged the cancellation or no show fee.

Example: Appointment on Monday at 9:00 AM must be cancelled no later than Friday at 9:00 AM

Patient Name: _____

Patient / Guarantor Signature: _____

Date: _____

Witness Signature: _____

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MEDICAL HISTORY – PRESENT PAIN / INJURY

PATIENT NAME: _____

REASON FOR VISIT: _____

WHEN DID THE PAIN OR INJURY OCCUR? _____

HAVE YOU SEEN ANOTHER ORTHOPAEDIC FOR TREATMENT? YES / NO

WHEN WAS THE LAST TIME YOU HAD TREATMENT? _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?
(Please mark one)

NUMBNESS:	YES	NO	NIGHT PAIN:	YES	NO
TINGLING:	YES	NO	WEAKNESS:	YES	NO
STIFFNESS:	YES	NO	HEADACHE:	YES	NO
LIMITED MOVEMENT:	YES	NO	BEND /EXTEND:	YES	NO

COMMENTS: _____

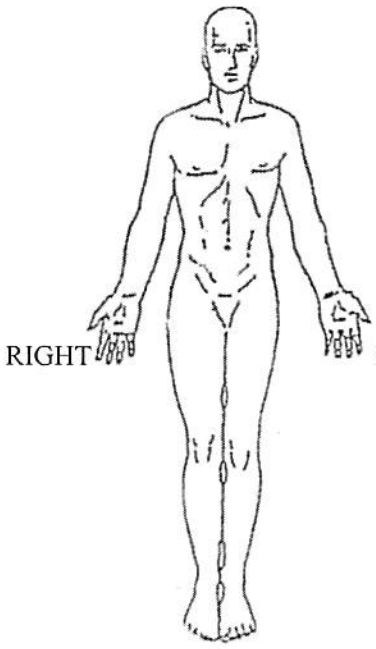
_____

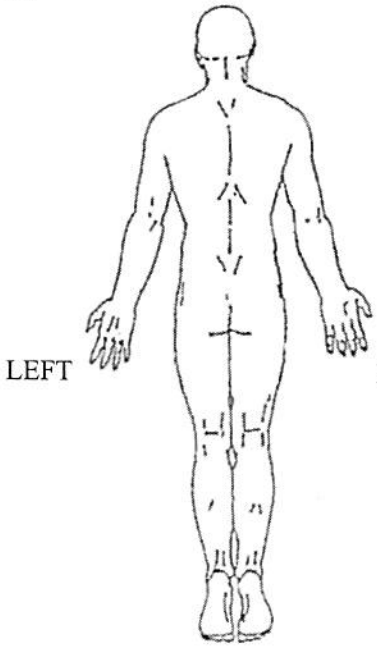
_____

_____

_____

PLACE AN "X" ON THE PART OF THE BODY THAT YOU ARE CURRENTLY EXPERIENCING PAIN OR HAVE A FRACTURE





SIGNATURE: _____ DATE: _____

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PATIENT'S MEDICAL HISTORY – AS OF _____

PATIENT NAME: _____ DOB: _____

PERSONAL HISTORY		FAMILY HISTORY	
High Blood Pressure	___	High Blood Pressure	___ Mother/Father
Heart Problem	___	Heart Problem	___ Mother/Father
Urinary Problems	___	Urinary Problems	___ Mother/Father
Kidney Problems	___	Kidney Problems	___ Mother/Father
Tuberculosis	___	Tuberculosis	___ Mother/Father
Intestinal/Stomach Problem	___	Intestinal/Stomach Problem	___ Mother/Father
Thyroid Problem	___	Thyroid Problem	___ Mother/Father
Respiratory Problem	___	Respiratory Problem	___ Mother/Father
Neurological Problem	___	Neurological Problem	___ Mother/Father
Diabetes	___	Diabetes	___ Mother/Father
Stroke	___	Stroke	___ Mother/Father
Gout	___	Gout	___ Mother/Father
Bleeding Ulcer	___	Bleeding Ulcer	___ Mother/Father
Bleeding Disorders	___	Bleeding Disorders	___ Mother/Father
Anemia	___	Anemia	___ Mother/Father
Phlebitis	___	Phlebitis	___ Mother/Father
Arthritis	___	Arthritis	___ Mother/Father
Cancer	___	Cancer	___ Mother/Father
Asthma	___	Asthma	___ Mother/Father
Migraine	___	Migraine	___ Mother/Father
Pacemaker	___	Pacemaker	___ Mother/Father

Do you Smoke? Yes / No Socially Drink? Yes / No Left or Right handed? Left / Right

Are you allergic to any medications? Yes / No If so, which medications? _____

Are you currently taking any medication? Yes / No If so, list them: _____

Have you ever had any Fractures or Dislocations? Yes / No

Which part of the Body?	When?	Did you have Surgery?

Have you ever had any Surgeries or Procedures done? Yes / No

Which part of the Body?	When?	Who was your surgeon?

Female Patients Only: Are you pregnant? Yes / No Are you on Birth Control? Yes / No

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Daniel G. Kalbac, M.D., F.A.C.S.
Sam Ash, M.D.

NOTICE OF PRIVACY PRACTICES
Revised 2005

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.

We understand that your medical information is personal and we are committed to protecting this information. We create a record of the equipment, services, and financial information about you. We use this record to provide you with quality equipment and services, and to comply with the certain legal requirements. This Notice applies to all of our records pertaining to your care. This Notice will tell you about the ways in which we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information. Privacy laws require that we ensure the following:

- We must maintain the privacy of your medical and financial information;
- We must provide you with this Notice, which explains our legal duties and privacy practices with respect to your protected health information; and,
- We must follow the terms of the Notice currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we can use and disclose protected health information. We will define and give some examples for each category of uses or disclosures listed below. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment – We may use and disclose your protected health information so that the equipment and services you receive may be billed to and payment may be collected from you, your insurance company or a third party. For example, we may need to give your insurance company information about a type of surgery you received at the hospital, so your insurance will pay us or reimburse you for the equipment you now require. We may also tell your health plan about the equipment you are going to receive to obtain prior approval or to determine whether your plan will cover that equipment.

For Health Care Operations – We may use your protected health information to evaluate the performance of our employees who serve you. For example, we may combine information about many of our patients to decide what additional services we should offer or what services are no longer necessary. We may also disclose information to doctors and other health care professionals that are also required by law to follow these privacy guidelines. For **Treatment** – We may use your protected health information to provide you with medical equipment or services. For example, we may gather information from your health care provider, such as a physician, nurse, or other person providing health services to you, and maintain that information in your record. This information is necessary for health care providers to determine what treatment you should receive.

Health-related Benefits and Services – We may contact you to tell you about health-related benefits or services that may be of interest to you. Individuals Involved in Your Care or Payment for Your Care – We may release your protected health information to a friend or family member who is involved in your medical care or who helps pay for your care.

As Required By Law – We will disclose our protected health information when required to do so by federal, state, or local laws. To Avert a Serious Threat to Health or Safety – We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another individual. Any disclosure, however, would only be to someone able to help prevent that threat. Public Health Risks – We may disclose your protected health information for public health activities.

Health Oversight Activities – We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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Lawsuits and Disputes – If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a Subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement – We may release your protected health information if asked to do so by law enforcement officials. National Security and Intelligence Activities – We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law to include protection of the President, other authorized persons or foreign heads of state, or in conducting special investigations.

YOU'RE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION
Right to Inspect and Copy – In accordance with 45 C.F.R. §164.524, you have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy your protected health information that may be used to make decisions about you, you must submit your request in writing to our Office Manager. We may deny your request to inspect and copy in certain, very limited, circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed health care professional chosen by Orthopaedic & Sports Medicine Center of Miami will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
Right to Amend – In accordance with 45. C.F.R. §164.526, if you feel that your protected health information that we possess 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 Orthopaedic & Sports Medicine Center of Miami. To request an amendment, your request must be made in writing and submitted to the Orthopaedic & Sports Medicine Center of Miami, Office Manager. Contact the Office Manager at their address for a request letter. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that is accurate and complete.
Right to an Accounting of Disclosures – In accordance with 45 C.F.R. §164,528, you have the right to request an accounting of disclosures. This is a list of instances in which we disclosed your protected health information. To request this account of disclosures, you must submit your request in writing to our Office Manager. Your request must state a time period, which may not be longer than six years and may not include dates prior to April 14, 2003. The first accounting of disclosures you request within a 12 month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the cost involved, so you may choose to withdraw or modify your request at that time before any costs are incurred. Right to Request Restrictions – In accordance with 45 C.F.R.§164.522(a), you have the right to request a restriction or limitation on the protected health information we use or disclose about you 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. For example, you could ask that we not tell a spouse about a medical procedure you recently had in a hospital. We are not required to agree with your request. If we do agree with your restriction request, we will comply unless the information is needed to provide you emergency treatment. To request restrictions, you must make the request in writing to our Office Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosure to your spouse.
Right to Receive Confidential Communications – In accordance with 45 C.F.R. §164.522(b), we communicate with you about confidential medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Changes To This Notice – We reserve the right to change this. Notice. The provisions in the new Notice will be effective for all protected health information that we maintain about you. Complaints – If you believe your privacy rights have been violated, you may file a complaint with or with the Secretary of the Department of Health Orthopaedic & Sports Medicine Center of Miami and Human Services. To initiate a complaint, please contact our Office Manager. To take action, all privacy complaints must be submitted in writing. You will not be retaliated against for filing a complaint. Other Uses of Protected Health Information – Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.