Welcome to Non-Surgical Orthopedics

Patient Information Today's Date_____

First Name_____MI____Last_____

Address_____

City _____STATE _____ ZIP_____

Birthday _____ Age____S.S.# _____

Home Tel. (____) _____Cell (____) _____Work (____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ **Phone:** _____

Please present a copy of the insurance card for each carrier

Primary Medical Insurance Company

Insurance Name: _____PolicyID_____

Policy Holder: _____Group ID_____

Date of Birth: _____SS# _____ MALE or FEMALE

Relationship CHOOSE ONE: Self Spouse Child Other _____Employer: _____

Secondary Medical Insurance

Insurance Company Name: _____Tel: _____

Insured's Name (if different that patient):_____DOB: _____

Address: _____ Tel: _____

Member ID: _____ GroupID:_____SS#:_____

Employer: _____ Tel:_____

Primary Care Physician_____Tel:_____

Who referred you to us?

_____

Welcome to Non-Surgical Orthopedics

Name: _____ Date of Birth: _____

Medical History Have you ever had the following? Please check all that apply!

___Heart disease	___Metal implants	___Anemia	___Migraines
___Diabetes	___Cancer	___Herniated disc	___Gout
___Epilepsy	___Thyroid disease	___Psychiatric disorder	___Stomach Ulcers
___Liver disease	___HIV/AIDS	___Hepatitis	___Pacemaker
___Kidney disease	___Stroke	___Osteoporosis	___Scoliosis
___Lung disease	___Blood Clots	___Brain Injury	___Spinal Injury

Please list any other conditions you would like to tell us about. (including musculoskeletal):

_____

_____

Family History Please check off if your relatives have had any of the following diseases.

Disease	Father	Mother	Brother/Sister	Grandparents
Arthritis	⬭ _____	⬭ _____	⬭ _____	⬭
Cancer	⬭ _____	⬭ _____	⬭ _____	⬭
Heart Disease	⬭ _____	⬭ _____	⬭ _____	⬭
Neurological Disease	⬭ _____	⬭ _____	⬭ _____	⬭

Social History

What are your hobbies? _____

What is your marital Status?	Single	Married	Widowed	Divorced
Do you smoke/chew tobacco?	Never	Social	Less than pack/day	More than pack/day
Do you drink alcohol?	Never	Occasionally	Regularly	Daily
Do you use recreational drugs?	Never	Occasionally	Regularly	Daily

Surgeries/Foreign Materials eg. Pacemaker, metal etc.

_____

_____

_____

Current Medications: Please include all prescriptions, over-the-counter medications, vitamins and herbal supplements.

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

Allergies to medication, food, or other. Please list allergy and state the reaction you had.

1. _____ 2. _____

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Name_____

Traumatic Injuries Please list all (if any):

_____

Are you having any of these symptoms? Please check off all that apply:

General:
___Anxiety
___Depression
___Ear Ache/Noise
___Fatigue
___Fever
___Loss of bladder
___Sleep Loss
___Skin Rash
___Weight Loss/Gain

Eyes, Ears, Nose, Throat:
___Earache/Noise
___Failing Vision
___Sinus Infection
___Enlarged Glands

Cardiovascular:
___Swelling Legs
___Pain over heart

Gastro:
___Nausea
___Pain over stomach

Musculoskeletal:
___Arm/Leg Pain
___Arm/Leg Weakness
___Painful/Swollen Joints
___Low Back Pain
___Neck Pain
___Sciatica

Neurological:
___Convulsions
___Headaches
___Numbness

Respiratory:
___Chronic cough
___Difficulty breathing

Reason for your visit:_____

Describe your condition: _____

Have you had any tests for your **current condition**? (mark all that apply, give date & results)

o X-rays_____ o MRI _____ o CT Scan _____ o CT Myelogram_____ o EMG _____

_____

Is this condition the result of an accident?

Yes No (If yes, please indicate) Work Auto Other _____ Date of Accident:_____

Women Only:
Are you pregnant or is there any possibility that you could be pregnant? **Yes** **No**

By my signature below, I hereby specifically authorize the physician and/or his agents to provide medical treatment to me. I also authorize Non-Surgical Orthopedics and/or Michael R. Hadley D.O. to release any medical and personal information acquired in the course of treatment that is necessary to process insurance claims, or receive payment from any payment entity and authorize my insurance company to make the payments for my medical services directly to the physician, realizing that I am responsible for any amount not covered/paid by my insurance. I also authorize the practice to release information that is requested by any physical therapy, diagnost imaging, labs or other physicians that the practice refers me to as part of my treatment.

Non-Surgical Orthopedics and East West Healing Solutions share only a common facility and a common purpose of providing quality care to every patient but are separate practices and not partners nor joint ventures.

Please give 24hr. Cancellation notice to avoid $30 charge

Patient Signature_____ Date_____

Guardian Signature_____ Date_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ CAREFULLY

Department of Health Duties

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at **www.myflorida.com** and will be available by email and at all Department of Health buildings.

Uses and Disclosures of your protected health information

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided to you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
- District medical examiner investigations.
- Research approved by the department.
- Court orders, warrants, or subpoenas.
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. This authorization will have an expiration date that can be revoked by you in writing. These uses and disclosures may be for marketing and for research purposes. Certain uses and disclosure of psychotherapist notes will also require your written authorization.

Individual Rights

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6-year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

For Further Information

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health, Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

Effective Date

This Notice of Privacy Practices is effective beginning April 14, 2003, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

References

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 65, No. 250 (December 28, 2000).

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register*, Vol. 67, No. 157 (August 14, 2002).

DH 150-741, 4/03; Stock Number: 5730-741-0150-0

I have had the opportunity to review Non-surgical Orthopedics privacy practices.

Signature _____ Name(print)_____ Date_____

Florida Department of Health
Office of the Inspector General
4052 Bald Cypress Way, BIN A-03
Tallahassee FL 32399-1704