

Lowcountry Bone & Joint Surgery, P.A.
1251B Ribaut Rd.
Beaufort, SC 29902
(843) 524-3015
New Patient Information Form

| | | |
|----------------------------|-------------------|---------------|
| | F / M | |
| Last Name | First Name | Middle |
| Gender (Circle One) | | |

| | | | |
|--|-------------|--------------|-----------------|
| Mailing Address (if Po Box, list street also) | City | State | Zip code |
|--|-------------|--------------|-----------------|

| | | | |
|-------------------|---------------|---------------|----------------|
| Home Phone | Work # | Cell # | Other # |
|-------------------|---------------|---------------|----------------|

| | | |
|----------------------|--------------------------|--|
| Date of Birth | Social Security # | Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Student |
|----------------------|--------------------------|--|

| | | |
|----------------------|-------------------------|------------------------|
| Employer Name | Employer Address | Employer Phone# |
|----------------------|-------------------------|------------------------|

| | | | |
|------------------------------|-----------------------------|----------------------|------------------------|
| Spouse or Parent Name | Spouse Date of Birth | Spouse Phone# | Spouse Employer |
|------------------------------|-----------------------------|----------------------|------------------------|

| | |
|---|-------------------|
| Emergency Contact (if other than spouse) | Phone #(s) |
|---|-------------------|

How did you hear about us? Dr. Referral Friend/Family Internet Other _____

Today's chief Complaint/Problem: _____

Is this related to an accident /injury? Yes No

If yes, what type of accident? MVA (motor vehicle accident) Slip & Fall Work Comp (see our staff for additional form to complete) Other(please explain) _____

Date of Accident _____ **State where occurred?** _____ **Attorney Name** _____

Guarantor/ Policyholder Insurance Information:
PLEASE PRESENT INSURANCE CARDS TO OFFICE STAFF

| | |
|----------------------------------|--------------------------------------|
| Primary Insurance Carrier | Guarantor / Policyholder Name |
|----------------------------------|--------------------------------------|

| | | |
|--------------------|---------------|-------------------------------------|
| ID/Policy # | Group# | Policyholder's Date of Birth |
|--------------------|---------------|-------------------------------------|

| | |
|------------------------------------|-------------------------------------|
| Secondary Insurance Carrier | Guarantor/ Policyholder Name |
|------------------------------------|-------------------------------------|

| | | |
|-----------------|---------------|-------------------------------------|
| Policy # | Group# | Policyholder's Date of Birth |
|-----------------|---------------|-------------------------------------|

RELEASE OF BENEFITS & INFORMATION

I authorize benefits to be paid directly to Lowcountry Bone & Joint, P.A. I understand I am financially responsible for any co-pays, co-insurances, or any non-covered items by my Insurance co. I hereby authorize this office and its staff members to release any medical or incidental information that may be necessary for other medical care or in the processing of claims for financial benefits.

| | | |
|---|--------------------------------|---------------------|
| Patient / Guarantor / Guardian Signature | Relationship to Patient | Today's Date |
|---|--------------------------------|---------------------|

(For office use only: Staff Initials _____)

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Please list any and all Prescriptions & Over the Counter Medications (including vitamins) currently taking:

| Medication Name | Dose | How Often | Ordering Dr. |
|-----------------|------|-----------|--------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all allergies to Medications, Foods or Metals (ie: Nickel products)

NKDA (No Known Drug Allergies)

Medical History: (Yourself) (Please check ones that apply)

- | | |
|---|--|
| <input type="checkbox"/> Cancer- Type: _____ | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes- Type: _____ | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Pulmonary Embolism (PE) |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stomach /GI Problems |
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Other _____ | |

Do you have a Pacemaker? Yes, Implant Date _____ No

Do you have an IVC filter? Yes, Implant Date _____ No

Family History: Is there a family history of: (Dad, Mom, Maternal Grandparents, Paternal Grandparents, Sister(s), Brother(s))

- | | | | |
|--|-------------------|---|-------------------|
| <input type="checkbox"/> Cancer | If so, who? _____ | <input type="checkbox"/> High Cholesterol | If so, who? _____ |
| <input type="checkbox"/> Diabetes | If so, who? _____ | <input type="checkbox"/> Hypertension | If so, who? _____ |
| <input type="checkbox"/> Heart Disease | If so, Who? _____ | <input type="checkbox"/> History of Blood Clots | If so, Who? _____ |
| Other _____ | | | |

Tobacco Use: If so, how long? _____

- None 1PPD 1/2 PPD 2PPD Less than ½ PPD Chew/Dip Other _____

Alcohol Use: None Social Mild Moderate Heavy

List all surgeries since Birth

Year of Procedure:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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Office hours are 8:30am-5:00pm, Monday-Friday

Please read & sign the following office policies. If you have any questions please ask our staff members to assist you.

Our office schedule is by appointments only. Please contact our office 24 hours prior to your appointment if you need to reschedule or cancel.

If you do not show for an appointment in 3 visits, this office has the right to terminate the physician/patient relationship.

Please allow up to 10-15 working days for disability forms to be completed. A \$10.00 fee for each form is required and must be paid prior to completion of form.

CONTROLLED SUBSTANCE POLICY: I understand Dr. Jones will **NOT** prescribe controlled substances for an extended length of time, including chronic problems. I will only be prescribed pain medicine as Dr. Jones feels is necessary for the diagnosis for which I am being treated. I understand that if Dr. Jones prescribes a controlled substance for me that I may not obtain controlled substances from another physician. Failure to notify Dr. Jones of this is also grounds for termination of the physician/patient relationship.

HIPAA Authorization:

I have been offered and/or received a copy of the Privacy Practices for the above named practice.

Authorization of Release of Information:

Can we leave information regarding your appts, surgery, results, financial or otherwise on your answering machine? Yes No Other _____

Please list below those who we may speak to or leave information with on your behalf and relationship: _____

Patient Rights:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as described in this document by sending written notification to Lowcountry Bone & Joint Surgery, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective forward. I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing the authorization. This authorization shall be in force and effect until revoked by the patient or changed by this practice.

Financial Responsibility Agreement

- **Payment is expected at the time of service.** Payment may be made by cash, check or credit card. Any deductible, co-insurance or co-payment is payable at the time of service. Estimates are given for patient responsibility according to contract benefits and are estimates only.
- **Payment Guarantee:** The undersigned agrees, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms of Lowcountry Bone & Joint Surgery, P.A. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where Lowcountry Bone & Joint Surgery, P.A. has a specific contract with my PPO, or third party payer. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay, within 120 days from date of service.
- In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for and pay in addition to the charges for services and treatment received, all cost reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, skip tracing costs, and court costs.
- **Lowcountry Bone & Joint Surgery, P.A. reserves the right to transfer unpaid balances to outside entities for collection.**

Patient /Guardian Signature
Staff Initials: _____

Date

**Lowcountry Bone & Joint Surgery, P.A.
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This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.

Lowcountry Bone & Joint Surgery, P.A.

**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 REVIEW IT
CAREFULLY.**

**If you have any questions about this Notice
please contact
our Privacy Officer who is the Office
Manager, _____.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**1. USES AND DISCLOSURES OF
PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. 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 or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity,

and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no

longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and

a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does 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. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

You have the right to request to receive confidential communications from us by

alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, at (843) 524-3015 or email address of lowcountryboneandjoint@yahoo.com for further information about the complaint process.

This notice was published and becomes effective on **04/01/03**
Revised on 04/29/10.