

NEW PATIENT     UPDATE

DR: \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT ACCT. #: \_\_\_\_\_

**PATIENT'S LEGAL NAME:**

(First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Last) \_\_\_\_\_ Sex: M F

Social Sec. #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M S W D

Address: \_\_\_\_\_ City, State and Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

School Name (if student): \_\_\_\_\_

Religious Preference: \_\_\_\_\_

Primary Physician Name and Phone: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_

**DATE OF INJURY:** \_\_\_\_\_

**RESPONSIBLE PARTY:** (If the patient is a minor, person responsible for billing account)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

City, State and Zip: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_

**PRIMARY INSURANCE:**

Insurance Company: \_\_\_\_\_ Primary Insured's Name: \_\_\_\_\_

Insured's Group #: \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

**SECONDARY INSURANCE:**

Insurance Company: \_\_\_\_\_ Primary Insured's Name: \_\_\_\_\_

Insured's Group #: \_\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

**HOW WERE YOU REFERRED TO US:** \_\_\_\_\_

**PLEASE READ:** Some insurance companies will not pay your bill if you do not select one of their participating physicians. It is the patient's responsibility to determine if our physician participates in your insurance plan. Payment or copayment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney's fees. By signature below, the parent or guardian agrees that the jurisdiction and venue for said action shall be the county of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).

**SIGNED** (Patient or Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND ASSIGNMENT:** I authorize The Orthopedic Center to release information regarding my treatment to my insurance co., to health care providers who have referred me to The Orthopedic Center and to parties who are involved in my treatment if I have a work related injury. I also authorize my insurance benefits to be paid directly to The Orthopedic Center or the individual physicians. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event The Orthopedic Center is served with a subpoena for production of records, the undersigned authorizes The Orthopedic Center to produce such records under a business records affidavit without the necessity of attendance at a deposition. This above authorization can only be withdrawn or revoked by written notification to The Orthopedic Center.

**SIGNED** (Patient or Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	DATE
Height _____ Weight _____ email address: _____			

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_  
Address: \_\_\_\_\_

**HISTORY OF YOUR PROBLEM**

Which arm is involved?     Right     Left      Dominant Hand?     Right     Left  
Occupation? \_\_\_\_\_  
Where do you work? \_\_\_\_\_  
How did you injure yourself? \_\_\_\_\_  
What do you feel is the cause of the problem? \_\_\_\_\_  
Are you involved in any litigation related to this problem?     Yes     No     Maybe  
Is this due to an injury?     Yes     No    Date of injury: \_\_\_\_\_  
Are you disabled?     Yes     No    If yes, please provide date the disability began: \_\_\_\_\_

**Is this a work-related injury?**     Yes     No

**If you answered yes to the above question, please fill out the back page.**

**Is this related to a motor vehicle accident?**     Yes     No    **Date of injury:** \_\_\_\_\_

Have you had Nerve Studies performed?     Yes     No  
If so, when? \_\_\_\_\_ Where? \_\_\_\_\_  
Have you had x-rays of the injured extremity taken?     Yes     No  
If so, when? \_\_\_\_\_ Where? \_\_\_\_\_  
Have you had an MRI performed?     Yes     No  
If so, when? \_\_\_\_\_ Where? \_\_\_\_\_

WHAT ARE YOUR PRESENT COMPLAINTS?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What treatment(s) have you tried so far?

<input type="checkbox"/> Rest/Activity Modification	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Pain Medication
<input type="checkbox"/> Physical Therapy/Exercises	<input type="checkbox"/> Massage	<input type="checkbox"/> Anti-inflammatories
<input type="checkbox"/> Immobilization (Cast, splint, sling)	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Steroid/Cortisone Injection
<input type="checkbox"/> Braces/Orthotics	<input type="checkbox"/> Electrical Stimulation	<input type="checkbox"/> Tylenol

## HOSPITALIZATIONS AND SURGERY

SURGERY		DATE	
MEDICATIONS	DOSE	MEDICATIONS	DOSE

**ALLERGIES:**

Are you allergic to Latex?  Yes  No

### REVIEW OF SYSTEMS (please circle)

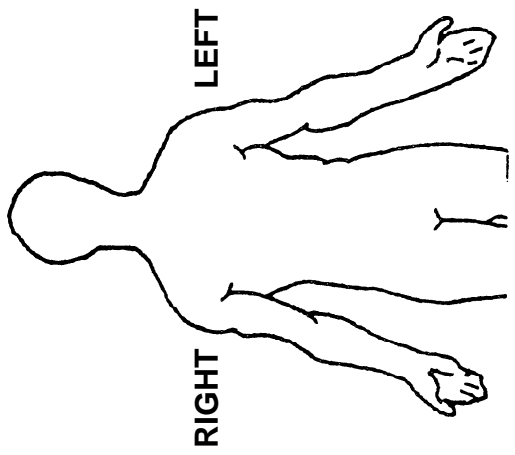
### PAST FAMILY HISTORY

<p><b>Childhood History - None</b></p> <p>Scarlet Fever      Rubella      Rheumatic Fever                      Polio                  Mumps      Diphtheria                      Measles              Tetanus</p> <p><b>Constitutional - None</b></p> <p>Fever                  Chills                  Weight Loss</p> <p><b>Ear, Nose, Throat - None</b></p> <p>Dizziness              Ear problems      Sinus problems                      Cold sore              Deafness              Motion sickness</p> <p><b>Cardiovascular - None</b></p> <p>Palpitations          Heart Murmur      Chest Pains                      High blood pressure      High Cholesterol                      Vascular Disease      Pacemaker</p> <p><b>Respiratory - None</b></p> <p>Asthma                  Bronchitis              Emphysema                      Pneumonia              Shortness of breath</p> <p><b>Gastrointestinal - None</b></p> <p>Ulcer                      Gall Bladder problems                      Hepatitis                  Diarrhea              Black Stool                      Blood in Stool</p> <p><b>Genitourinary - None</b></p> <p>Prostate Disease      Frequent urination                      Painful urination      Blood in urine</p> <p><b>Musculoskeletal - None</b></p> <p>Arthritis                  Joint pains              Gout                      Rheumatoid arthritis</p> <p><b>Endocrine - None</b></p> <p>Diabetes                  Thyroid Disease</p> <p><b>Neurologic - None</b></p> <p>Headaches              Migraines              Seizures                      Stroke</p> <p><b>Psychiatric - None</b></p> <p>Depression              Nervousness              Anxiety</p> <p><b>Hematologic/Lymphatic - None</b></p> <p>Bleeding problems      Anemia                  Easy Bruising</p> <p><b>Skin - None</b></p> <p>Rashes                      Itching</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 5%;">Self</th> <th style="width: 5%;">Father</th> <th style="width: 5%;">Mother</th> <th style="width: 5%;">Father's Parents</th> <th style="width: 5%;">Mother's Parents</th> <th style="width: 5%;">Siblings</th> <th style="width: 5%;">Children</th> </tr> </thead> <tbody> <tr><td style="text-align: right;">Heart Disease</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td style="text-align: right;">High Blood Pressure</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td style="text-align: right;">Stroke</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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Drug Abuse? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>HIV Tested? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Hobbies: _____</p> <p>_____</p>		Self	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input 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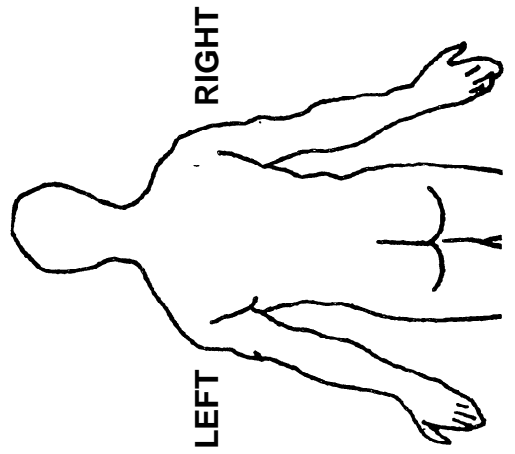
INDICATE THE LOCATION AND TYPE OF PAIN YOU ARE HAVING. DRAW YOUR PAIN WITH THE SYMBOLS LISTED.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING	SCAR
AAAA	.....	000000	XXXX	//////	^^^

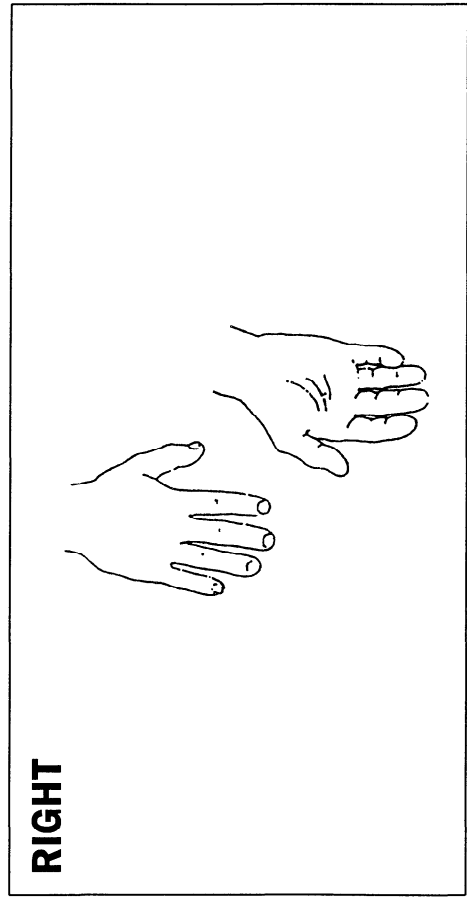
FRONT



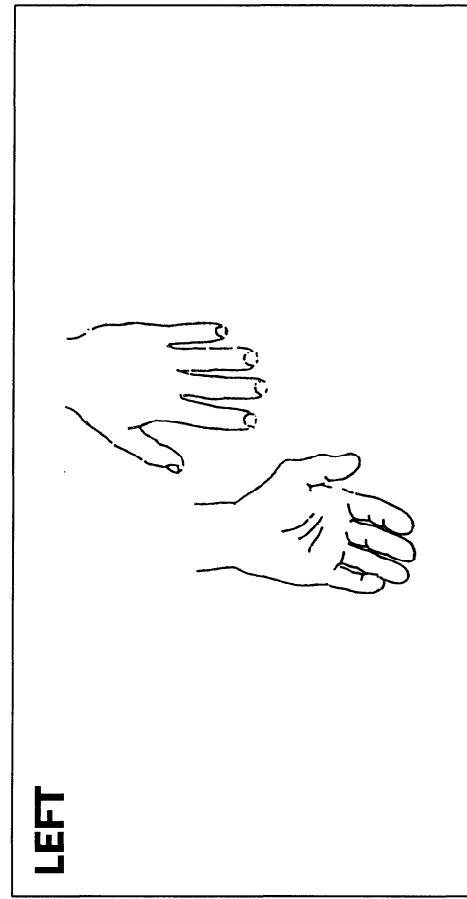
BACK



RIGHT



LEFT



**Complete this section only if you are here for a work-related problem**

**Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible.**

**WORK HISTORY**

**What is your current occupation?** \_\_\_\_\_

**What company do you currently work for?** \_\_\_\_\_

**What was your occupation when you developed the problem that you are being seen for?** \_\_\_\_\_

**What company were you working for when you developed this problem?** \_\_\_\_\_

**When did you first start working for this company?** \_\_\_\_\_

**If you are no longer working for this company, when did you last work for this company?** \_\_\_\_\_

**How many hours a day do you (or did you) work?** \_\_\_\_\_

**How many hours a week do you (or did you) work?** \_\_\_\_\_

**Describe your job in detail:** (i.e., The job you were performing when you developed your problem; what you do with your hands and arms at work; how often you perform these activities; how much you lift and how often; whether or not you do data entry - how many hours per day and note if it is continuous or intermittent; if you do repetitive work, how many times per hour this is performed.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a second job?**  Yes  No

**If yes, please describe what you do and the number of hours per day and week that you work there:**

\_\_\_\_\_  
\_\_\_\_\_

**Past Work History**

**Please list the type of work you did before you worked for the company you were working for when you developed this problem:** (i.e., Where you worked; how long you worked there – when to when; and what you did there.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you currently working your regular job?**  Yes  No

**Are you on light duty?**  Yes  No

**If you are on light duty, what are your work restrictions?** \_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# The Orthopedic Center of St. Louis

## NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2013

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 are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our medical group, its medical staff and affiliated health care providers who jointly perform health care services with our medical group, including physicians and physician groups who provide services at our facilities. A copy of our current notice will always be posted at all registration and/or admission points. You will also be able to obtain your own copies by accessing our website at [www.toc-stl.com](http://www.toc-stl.com) or calling the Privacy Officer at 314.336.2555.

*If you have any questions about this notice or would like further information, please contact the above referenced individuals.*

### WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient of our medical group or receiving health-related services from our facilities, information about your health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

### REQUIREMENT FOR WRITTEN AUTHORIZATION

Generally, we will obtain your written authorization before using your health information or sharing it with others outside of our medical group. There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

**Marketing.** We may not disclose any of your health information for marketing purposes if our medical group will receive direct or indirect financial remuneration not reasonably related to our medical group's cost of making the communication.

**Sale of Protected Health Information.** We will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive remuneration for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or

part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical group's behalf, or for other purposes as required and permitted by law.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our medical group. You may also initiate the transfer of your records to another person by completing a written authorization form.

### HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

#### 1. **Treatment, Payment and Health Care Operations.**

**Treatment.** We may share your health information with doctors or nurses at the medical group who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor in our medical group may share your health information with another doctor to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

**Payment.** We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

**Health Care Operations.** We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

#### 2. **Appointment Reminders, Treatment Alternatives, Benefits and Services.** In the course of providing treatment to

you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

**3. Business Associates.** We may disclose your health information to contractors, agents and other “business associates” who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information. If our business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

**4. Friends and Family Designated to be Involved In Your Care.** If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

**5. Proof of Immunization.** We may disclose proof of a child’s immunization to a school, about a child who is a student or prospective student of the school, as required by State or other law, if a parent, guardian, other person acting in loco parentis, or an emancipated minor, authorizes us to do so, but we do not need written authorization.

**6. Emergencies or Public Need.**

**Emergencies or As Required By Law.** We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you. We may use or disclose your health information if we are required by law to do so, and we will notify you of these uses and disclosures if notice is required by law.

**Public Health Activities.** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if permitted by law. We may disclose a child’s proof of immunization to a school, if required by State or other law, if we obtain and document the agreement for disclosure from the parent, guardian, person acting in loco parentis, an emancipated minor or an adult. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws.

**Victims Of Abuse, Neglect Or Domestic Violence.** We may release your health information to a public health authority authorized to receive reports of abuse, neglect or domestic violence.

**Health Oversight Activities.** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facilities. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

**Lawsuits And Disputes.** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if required judicial or other approval or necessary authorization is obtained.

**Law Enforcement.** We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, if we suspect that your death resulted from a crime, or if necessary, to report a crime that occurred on our property or off-site in a medical emergency.

**To Avert A Serious And Imminent Threat To Health Or Safety.** We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

**National Security And Intelligence Activities Or Protective Services.** We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

**Military And Veterans.** If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

**Inmates And Correctional Institutions.** If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary

to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

**Workers' Compensation.** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

**Coroners, Medical Examiners And Funeral Directors.** In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.

**Organ And Tissue Donation.** In the event of your death or impending death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

**7. Completely De-identified Or Partially De-identified Information.** We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

**8. Incidental Disclosures.** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

**9. Fundraising.** We may use or disclose your demographic information, including, name, address, other contact information, age, gender, and date of birth, dates of health service information, department of service information, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication made to you, you will have the opportunity to opt-out of receiving any further fundraising communications. We will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.

**10. Changes to this Notice.** We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. We will notify you of any changes.

## **YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

*You have the following rights to access and control your health information:*

**1. Right To Inspect And Copy Records.** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. If you would like an electronic copy of your health information, we will provide you a copy in electronic form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed.

**2. Right To Amend Records.** If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records by writing to us. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

**3. Right To An Accounting Of Disclosures.** You have a right to request an "accounting of disclosures," which is a list with information about how we have shared your health information with others. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer. You have a right to receive one list every 12-month period for free. However, we may charge you for the cost of providing any additional lists in that same 12-month period.

**4. Right to Receive Notification of a Breach.** You have the right to be notified if there is a probable compromise of your unsecured protected health information if the breach poses a significant risk of identity theft, financial, reputational or other harm to you within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

**5. Right To Request Restrictions.** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. You also have the right to request that your health information not be disclosed to a health plan if you have paid for the services in full, and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. To request restrictions, please write to the Privacy Officer. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to



provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so.

6. **Right To Request Confidential Communications.** You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home, by notifying the registration associate who is assisting you. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

7. **Right To Have Someone Act On Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

8. **Right To Obtain A Copy Of Notices.** If you are receiving this notice electronically, you have the right to a paper copy of this notice. We may change our privacy practices from time to time. If we do, we will revise this notice and post any revised notice in our registration area and on our website

9. **Right To File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us by calling the Privacy Officer at 314.336.2555, or with the Secretary of the Department of Health and Human Services. The hospital will not withhold treatment or take action against you for filing a complaint.

10. **Use and Disclosures Where Special Protections May Apply.** Some kinds of information, such as HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

**THE ORTHOPEDIC CENTER OF ST. LOUIS**

**ACKNOWLEDGMENT AND CONSENT**

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.*

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Signature of Patient or Personal Representative

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Print Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority

Dear Friends and Patients,

Thank you for choosing **The Orthopedic Center of St. Louis**.

**The Orthopedic Center of St. Louis** constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- 8 Fellowship Trained Orthopedic/Plastic & Reconstructive Surgeons with subspecialty training in specific areas.
- Digital x-rays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the first floor at **Imaging Partners of Missouri**
- **CT Partners & MRI Partners of Chesterfield** provides state of the art CT & MRI scanning on the first floor
- Electrodiagnostic testing on the third floor at the **Neurological & Electrodiagnostic Institute**
- **Athletico** on the third floor provides physical therapy and custom splinting, often the same day as your appointment at **The Orthopedic Center of St. Louis**
- Medical Equipment (DME) is available on-site through our office and **SSM RX Pharmacy** delivers medications to each of the following surgical facilities and some of our Surgeons dispense medications in-house to save you a trip to the drugstore.
- **Pain & Rehabilitation Specialists of St. Louis** specializes in interventional pain management and non-operative spine treatment

If surgery is required, **Timberlake Surgery Center** and **Orthopedic Ambulatory Surgery Center** are located on the 1<sup>st</sup> floor. **The St. Louis Spine and Orthopedic Surgery Center** are located nearby and provide additional locations for outpatient surgeries, spine patients, and patients who require an overnight stay. These facilities are staffed with experienced nurses and staffs that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

### **Financial Disclosure**

Some of the individual physicians at The Orthopedic Center of St. Louis have ownership in some of the surgical and imaging facilities listed above as permitted by both state and federal law.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website **www.TOC-STL.com**

We appreciate the opportunity to serve you and your family.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ TOC: \_\_\_\_\_



Mahesh R. Bagwe, M.D.  
David M. Brown, M.D.  
Matthew F. Gornet, M.D.  
Lyndon B. Gross, M.D., Ph. D.  
John O. Krause, M.D.

Mark D. Miller, M.D.  
George A. Paletta Jr., M.D.  
Mitchell B. Rotman, M.D.  
Luke S. Choi, M.D.  
Nathan A. Mall, M.D.

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## Consent to Release Information

I, \_\_\_\_\_, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends, or legal counsel with whom we are allowed to discuss your treatment or billing issues.)

\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ Relation: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian Signature if a minor)

Patient Signature (2<sup>nd</sup> Annual): \_\_\_\_\_ Date: \_\_\_\_\_