OSBORNE ORTHOPEDIC GROUP, INC.

PATIENT INFORMATION (please print)

Name:(Last)_____ (First)_____(Middle)_____

Address:(Street/P.O.Box) _____

City _____ **State** _____ **Zip** _____

Email: _____

Date of Birth: _____ **Age:** _____ **SS#:** _____-_____-_____

Phone Number(s):(Home) _____ (Cell) _____ (Work)_____

PCP (with phone number): _____ **Referred By:** _____

(Circle One) Single Married Widowed Divorced **Gender:** M F

Employer Name: _____

Employer Address: _____

Emergency Contact Person: _____
(Name) (Relationship to you) (phone)

Billing Info (Person Responsible for Paying the Bill)

Name: _____ **Relationship to Patient** _____

SS# _____-_____-_____ **Birthdate:** _____

Primary insurance: _____ **Policy #** _____

Policy Holder Name: _____ **Group #** _____

Secondary Insurance: _____ **Policy #** _____

Policy Holder Name: _____ **Group #** _____

I consent to treatment by the physicians and/or associates of Osborne Orthopedic Group, Inc.
I assign my insurance disbursement to be paid directly to Osborne Orthopedic Group, Inc. I understand that billing my insurance company does not guarantee payment from the insurance company to Osborne Orthopedic Group, Inc, and that I am financially responsible for payment of all charges.

Signature: _____date_____

OSBORNE ORTHOPEDIC GROUP, INC.

Health History

NAME _____DATE_____
REASON FOR YOUR VISIT TODAY: _____
Circle one: **auto accident work accident other** INJURY DATE: _____
Medications (List all medications -use back of sheet if more space is needed)

Medication Name	Dosage	Reason for Medication

Do you take aspirin containing medication? N Y _____

Allergies:

_____

Surgeries and Hospitalizations	**Year**	**Complications?**

Have you had general anesthesia? Y N **Problems with it?**_____
Occupation (Include student, retired, etc.)_____
Do you live alone? Y N How often Do you exercise? _____
Type of exercise: _____Substance abuse history?_____
Currently smoke? Y N How much? _____How long _____yrs
Quit smoking when?_____Used to smoke_____Per day for _____yrs
Drink alcohol (circle one) Daily 1-2x/week 1-2x/month 1-2x/year Never

Do you have problems with the following? ***(Describe)***

Arthritis	y n	_____
Eyes (Glasses)	y n	_____
Ears (Hearing Device)	y n	_____
Nose/Throat	y n	_____
Digestion	y n	_____
Diabetes	y n	_____
High Blood Pressure	y n	_____
Bleeding Problems	y n	_____
Balance Problems	y n	_____
Numbness/Tingling	y n	_____
Blackout/Fainting	y n	_____
Mental illness	y n	_____
Hiv/aids or Polio	y n	_____
Cancer or Epilepsy	y n	_____
Tuberculosis (tb)	y n	_____

Patient Signature: _____ Date_____

NOTICE OF PRIVACY PRACTICES SUMMARY

(Effective March 15, 2004)

THIS NOTICE DESCRIBES HOW OSBORNE ORTHOPEDIC GROUP, INC USES AND DISCLOSES YOUR MEDICAL INFORMATION AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE OF PRIVACY PRACTICES (NPP). IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT *JUDY GIDDENS, PRIVACY OFFICIAL FOR OSBORNE ORTHOPEDIC GROUP, INC. AT 757-548-7190*.

This NPP applies to Osborne Orthopedic Group, Inc. and all its locations, employees, to Healing Hands Physical Therapy and Advanced Podiatry of Hampton Roads. All entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or healthcare operations.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality healthcare and to comply with certain legal requirements. This notice applies to all of the records of your healthcare services by Osborne Orthopedic Group, Inc, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to (1) make sure health information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of this notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. By submitting to our care, you give us the right to use your information for treatment, to be reimbursed for the services rendered in order to care for you, and to operate our organization within the parameters of legality. We may use or disclose your information for the following reasons: appointment reminders; to evaluate the quality of the medical care we provide; to coordinate reimbursement for the services we provide to you; to fulfill requirements of subpoenas, lawsuits, and disputes; various uses as required by law or to avert a serious threat to health or safety. We coordinate some of your services by telephone. While every attempt is made to maintain quiet, private modes of conversation, passersby may overhear words or phrases regarding you or your treatment.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding the medical information we maintain about you: right to inspect and copy; right to amend; right to an accounting of disclosures; right to request restrictions; right to request confidential communications; and the right to a paper copy of this notice. Information about how to exercise these rights can be obtained from Judy Giddens, Privacy Official for Osborne Orthopedic Group, Inc., at 757-548-7190.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date. In addition, each time you register for medical treatment, we will offer you a copy of the current notice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Jennifer Osborne, Privacy Official, 757-548-7190. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of 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 health 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 health 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.

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT and AUTHORIZATION

I acknowledge that I have received the *Notice of Privacy Practices* for Osborne Orthopedic Group Inc. I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, and obtaining payment for my healthcare.
I may be contacted by telephone at the following numbers. Messages to return the office call and appointment reminders can be left at these numbers. (Personal Health Information such as test results **CANNOT** be left on an answering machine. Personal Health Information can only be shared with other people authorized by the patient.)

HOME #_____

CELL # _____

WORK # _____

OTHER # _____

I authorize the following people to receive my Personal Health Information (test results, prescription information, appointment information, specialist appointments, diagnostic testing, treatment plan, hospital care):

NAME _____RELATIONSHIP _____ # _____

NAME _____RELATIONSHIP _____ # _____

NAME _____RELATIONSHIP _____ # _____

This authorization will remain in effect from today until I request in writing that it be amended.

_____ _____
Signature of Patient or Guardian Date

_____ _____
PRINT Name of Patient or Guardian Witness Signature

OSBORNE ORTHOPEDIC GROUP, INC.

Narcotic prescription policy

Due to the possibility of chemical dependency upon these medications, Osborne Orthopedic Group, Inc. requires you to submit to the following policy:

I agree that the doctor has the right to decide what pain medication is best for me.

If the doctor prescribes a narcotic pain medication for me, I agree that I will not seek another narcotics prescription from any other doctor.

I understand that if I do obtain another narcotics prescription from an additional doctor at the same time I am using Dr. Osborne's narcotic prescription, Dr. Osborne will no longer give me that medication.

_____ _____

(Patient's Signature) **(Date)**

OSBORNE ORTHOPEDIC GROUP, INC.

CREDIT AND FINANCIAL POLICY

Thank you for choosing Osborne Orthopedic Group, Inc. as your healthcare provider. We are committed to the success of your treatment. Please understand that prompt payment of your charges is considered part of that treatment. Details of our CREDIT AND FINANCIAL POLICIES are listed. Please read carefully and sign below.

All patients complete our registration and insurance forms.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

For your convenience, we accept cash, checks, MasterCard and VISA.

We offer payment plans with prior approval and a signed agreement.

In the event the payment agreement is not honored, the entire balance on the account will be due.

If your services/accounts are in litigation, please note that Osborne Orthopedic Group, Inc. does not provide services on a contingency basis. Payment is expected at the time services are rendered, unless other arrangements have been made.

A service charge of $40.00 will be added to your account for all returned checks. If more than 2 (two) checks are returned, we will only accept cash or credit card payment for any outstanding charges and for any future services rendered.

A $25 fee will be assessed to your account for a no-show with failure to cancel/ reschedule an appointment with 24 hours notice. (757-548-7190)

A $100 fee will be assessed to your account for a no-show with failure to cancel/ reschedule surgery with 48-hour notice. (757-548-7190)

PATIENTS WITH INSURANCE COVERAGE

We accept assignments of insurance benefits. However, we do require your co-payment, coinsurance, and deductibles to be paid at the time of service.

The balance incurred is your personal responsibility whether your insurance carrier pays or not.

Coverage amounts vary from insurance policy to policy, and we cannot guarantee the amounts of coverage offered by your insurance carrier.

It is your responsibility to seek coverage amounts and limits of liability on your insurance policy.

You understand that your insurance policy is a contract between you and your insurance carrier. Osborne Orthopedic Group, Inc. holds no party to that contract and will not be held responsible in the event your insurance company denies any claims.

DELIQUENCY

In the event your account becomes past due and is sent to collections, you will be responsible for the collection costs along with attorney fees, interest, and court costs incurred by Osborne Orthopedic Group, Inc.

I have read and understand the Osborne Orthopedic Group, Inc. CREDIT AND FINANCIAL POLICY with respect to payment on my account.

_____ _____

Signature of Patient of Responsible Party **Date**