Tier Orthopedic Associates, PC
100 Plaza Drive
Vestal, NY 13850
607-798-9356

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes, treatment, payment and health care operations.

- **Treatment**: means providing, coordinating, or managing health care and related services by one or more health care providers.

- **Payment**: means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

- **Health care operations**: include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information , including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office by speaking with our Privacy Official or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT.

I Understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Tier Orthopedic Associates, P.C. has the right to change the Notice of Privacy Practices from time to time and that I may contact Tier Orthopedic Associates, P.C. at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

I do herby acknowledge that I have received a copy of the Notice of Privacy Practice.

Patient Name: ____ Date: ________________

Signature of Patient or Legal Guardian:____

Relationship to patient: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature and acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below.

Reason: ____

Signature: ____Date: _______________

TIER ORTHOPEDIC ASSOCIATES, P.C.

100 Plaza Drive - Vestal, New York 13850
Telephone 798-9356

Social Security No. ____________

PATIENT INFORMATION

PATIENT NAME:

First Name ____________ Middle Initial ____

Last Name ____________

Patient's Address ____________

City ____________ Zip Code ____________

Phone No.________ Age ______ Date of Birth ________

Sex: Male ____________ Female ____________

Primary Care Physician/Referring Physician:

____

Patient's Employer ____________

Work Phone ____________

Spouse's Name or Nearest Relative ____________

Address ____________

Phone No. ____________

Employed by ____________

IF CHILD:

Parent's Name ____________

Employed by ____________

WHAT ARE YOU BEING SEEN FOR?

Right ______ Left ______ Body Part ____________

WERE X-RAYS TAKEN? Yes __ No __ Where ________ When ______

WERE MRI'S TAKEN? Yes __ No __ Where ________ When ______

WAS EMG DONE? Yes __ No __ Where ________ When ______

INSURANCE INFORMATION:

WERE YOU INJURED AT WORK?

Yes __ No __ Date of injury ____________

Comp Carrier ____________

WERE YOU INJURED IN AN AUTO ACCIDENT?

Yes __ No __ Date or Accident ____________

PRIMARY INSURANCE CO. ____________

ID No. ____________

Subscriber ____________

SECONDARY INSURANCE CO. ____________

ID No. ____________

Subscriber ____________

OFFICE USE ONLY

DOCTOR ____________

DATE SEEN ____________

Initial ____________

MEDICAL INSURANCE WAIVER

I, THE UNDERSIGNED, AGREE TO THE PROVISION THAT IF MY MEDICAL INSURANCE DOES NOT COVER ANY AND ALL EXPENSES INCURRED DURING THE COURSE OF MY MEDICAL TREATMENT, I AM RESPONSIBLE FOR SAID PAYMENTS.

____

PATIENT OR GUARDIAN SIGNATURE

DATE ____________

Payment Authorization to Provider ____________

FOR OFFICE USE ONLY Account No. X-Ray No.

TIER ORTHOPEDIC ASSOCIATES, P.C. *100 Plaza Drive, Vestal, NY 13850 Phone 607-798-9356*

PATIENT/FAMILY MEDICAL HISTORY

Date **Birthdate** **Age** **SSN**

Name **Male** **Female**

Address **Telephone**

Occupation

Primary Care Physician/Referring Physician

Were x-rays brought with you? **Where taken?**

Nearest Relative **Relationship** **Phone**

CHIEF COMPLAINT

Why are you seeing the doctor today? ______________________

Current problem is the result of a(n): Please check all that apply:

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication

ALLERGIC TO:

☐ Antibiotics, what: ______________________

☐ Aspirin ☐ Codine ☐ Other ______________________

Are all immunizations up to date? ☐ Yes ☐ No

If no, which immunizations are due? ______________________

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	Circle		Describe all "Yes" responses
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	
Chest Pain, Heart Problems	No	Yes	
Digestion	No	Yes	
Bowel movement	No	Yes	
Bladder problem	No	Yes	
Diabetes	No	Yes	
High blood pressure	No	Yes	
Bleeding problems	No	Yes	
Balance problems	No	Yes	
Numbness/tingling	No	Yes	
Blackout/fainting/seizure	No	Yes	
Psychological Problems	No	Yes	
AIDS	No	Yes	
Cancer	No	Yes	
Arthritis	No	Yes	
Polio	No	Yes	
TB	No	Yes	
Epilepsy	No	Yes	
Liver	No	Yes	
Hepatitis	No	Yes	
Kidney	No	Yes	

** PLEASE SEE OTHER SIDE **

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? ☐ **NO** ☐ **YES**

Have any problems with anesthesia? ☐ **NO** ☐ **YES**

Describe: ____________________________________

FAMILY HISTORY (IMMEDIATE FAMILY ONLY):

Member	Alive	Deceased	Age	Health status or cause of death

Do any diseases run in your family-Describe:

SOCIAL HISTORY

☐ **Work in the home** ☐ **Employed (occupation ______________________________)** ☐ **Student** ☐ **Daycare** ☐ **Retired**

☐ **Employed (occupation______________________________)** **Currently Working** ☐ **Yes** ☐ **No**

Regular Duty ☐ **Yes** ☐ **No** **Restricted Duty** ☐ **Yes** ☐ **No** **If Yes, please state restrictions** ____________________

Who took you out of work or put you on light duty? ____________________

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Children? ☐ **No** ☐ **Yes #** ______________________________

Do you live alone? ☐**No** ☐ **Yes**

Exercise? ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Rarely** ☐ **Never**

What type of exercise? ____

History of substance abuse? ☐ **No** ☐ **Yes** **What?**

____

Smoke currently? ☐ **No** ☐ **Yes** _______ **Packs per day for** _______ **years.**

Quit smoking? ☐ **This year** ☐ **> 1 year** ☐ **> 5 years** ☐ **> 10 years** **Height:**__________ **Weight** __________

Previously smoked _______ **packs per day for** _______ **years.**

Drink alcohol? ☐ **Daily** ☐ **1-2 x/week** ☐ **1-2 x/month** ☐ **1-2 x/year**

<u>INSURANCE MEDICAL RELEASE/ASSIGNMENT:</u>
I hereby authorize release of medical information necessary to process my insurance claim, and I also hereby authorize payment directly to the physician for benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization.

Patient Signature:______________________________ ***Date:*** ____________________

Reviewed by: ______________________________ ***, M.D.*** ***Date:*** ____________________

TIER ORTHOPEDIC ASSOCIATES
100 PLAZA DRIVE
VESTAL, NY 13850

Authorization to Share Information

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

PATIENT NAME: ______________________________ **DOB:** ____________________

Leave appointment and billing messages on/with:			**Leave medical information messages on/with:**		
Answering machine?	___ **Yes**	___ **No**	**Answering machine?**	___ **Yes**	___ **No**
Office Voice Mail?	___ **Yes**	___ **No**	**Office Voice Mail?**	___ **Yes**	___ **No**
With another person?	___ **Yes**	___ **No**	**With another person?**	___ **Yes**	___ **No**
Send through the mail?	___ **Yes**	___ **No**	**Send through the mail?**	___ **Yes**	___ **No**
Send via email?	___ **Yes**	___ **No**	**Send via email?**	___ **Yes**	___ **No**
Cell Phone?	___ **Yes**	___ **No**	**Cell Phone?**	___ **Yes**	___ **No**

If you answered YES to allowing us to discuss your appointment, billing and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name:	**Relationship:**	**Phone:**	**Cell Phone:**

Additional HIPAA Contact instructions:

____

____

____

____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: ______________________

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP: ______________________

DATE: ______________________

This authorization will expire one year from the date of signature, unless otherwise notified.