New/Updating Patient Form

PLEASE PRINT ALL INFORMATION NEEDED BELOW, THANK YOU

Today's Date _____

Patient's Name: _____ **Gender: □Male □Female**
Last First MI

Patient Mailing Address: _____
Street Address City State Zip

Best Phone: ( ) _____ 2nd Phone: ( ) _____

Date of Birth: _____ Social Security #: _____

Marital Status: □ Single / Soltero □ Married / Casado □ Divorced / Divorciado □ Seperated / Separado □ Widowed / Viudo(a)
□ Domestic partner / Compañero doméstico Spouse's Name: _____

PREFERRED LANGUAGE: _____ **EMAIL ADDRESS**: _____

If patient is under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ Social Security #: _____

Phone # (if different from above): _____ (day) _____ (evening)

Address (if different from above):
_____
Street Address City State Zip

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient:_____

Home Phone: ( ) _____ Work Phone: ( )_____

Primary Care Physician: _____ **Referring Physician (if different):**_____

Phone Number: ( ) _____ Fax Number: ( )_____

PRIMARY INSURANCE COVERAGE INFORMATION

Insurance Company Name:
_____
Insurance Co. Address:
_____
Street/ P.O. Box City State Zip
Policy ID #: _____ Effective Date of Coverage:_____

Group #: _____

Policy Holder's Name: _____
Last First MI

Policy Holder's Address:
_____
Street Address City State Zip

New/Updating Patient Form

Patient's Relationship to Policy Holder: □ SELF □ SPOUSE □ CHILD □ OTHER: _____

SECONDARY INSURANCE COVERAGE INFORMATION

Insurance Company Name:
_____

Insurance Co. Address:
_____
Street/ P.O. Box City State Zip

Policy ID #: _____ Effective Date of Coverage:
_____

Group #: _____

Policy Holder's Name: _____
Last First MI

Policy Holder's Address:
_____
Street Address City State Zip

Patient's Relationship to Policy Holder: □ SELF □ SPOUSE □ CHILD □ OTHER: _____
_____

ACCIDENT INFORMATION

AUTO ACCIDENT □YES □NO Date of Injury: _____

OTHER ACCIDENT □YES □NO Date of Injury: _____

WE DO NOT PROVIDE 3RD PARTY BILLING

WORKER'S COMPENSATION INJURY: □□YES □□NO Date of Injury: _____

Employer at Time of Injury:
_____

Employer Address: _____
Street/ P.O. Box City State Zip

Employer Phone: ( ) _____

Describe your injury (including body part involved):
_____

_____
_

NO SHOW POLICY

Please be advised that Orthopaedic Associates, USA has a "No Show" Policy. This means that if you do not keep your appointment OR cancel your appointment within 24 hours of the scheduled time, a $50.00 charge will be incurred.

New/Updating Patient Form

Medical History Questionnaire

Please answer all of the following questions to the best of your ability and sign your name at the end of this form.
Por favor, responda todas las preguntas lo mejor que usted pueda y firme su nombre al final de este formulario.

Patients Name / *Nombre del Paciente:* _____ **Age/** *Edad***:**_____

Dominant Hand: □Right □Left **Occupation** / *Ocupación*: _____

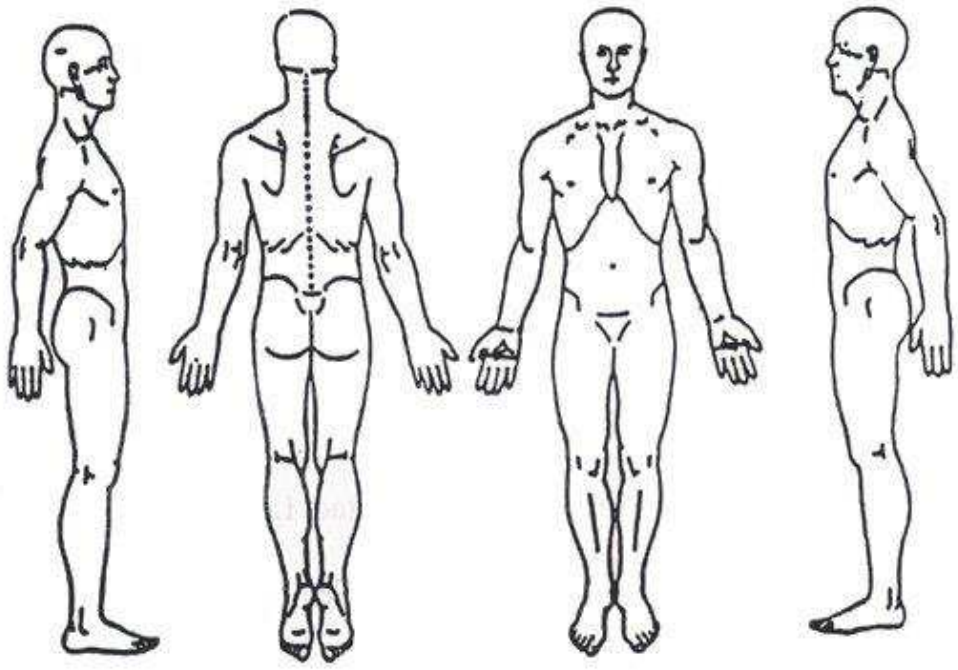
Height / Estatura: _____ **Weight** / Peso: _____

History of Present Illness

What did you injure? / *¿Qué parte del cuerpo se lesionó?*
_____

Which side? / *¿Cuál lado?*
Left ___ *Izquierdo* Right ___ *Derecho*

Mark problem areas of pain/ Marque la(s) parte(s) del cuerpo que le duele(n) y el tipo de dolor
*XXX=aching (dolor) | - - - = burning (ardor) | *** = pins & needles (alfileres & agujas)| >>> = shooting (sensación de disparo) | / // = stabbing (sensación de puñalada) | 000 = throbbing (sensación de palpitación)*



RT **LT** **RT** **RT** **LT** **LT**

How did you injure yourself?/ ¿Cómo se lesionó?
□ **No Injury** □**Fall** □ **MotorVehicle Accident** □**Work/Job** □**Sports**

Please briefly describe injury/ Por favor describa cómo se lesionó: _____
_____

New/Updating Patient Form

_____
_____

Date of Injury/ ***Fecha de la lesión:*** **_____**

Is this case involved or will it be involved in litigation? / ¿Está este caso relacionado con una demanda o va a estar en una demanda? □ Yes / Sí □ No / No

How long have you been experiencing these symptoms? / ***¿Cuánto hace que experimenta estos síntomas?***
_____Days/Días _____Months/Meses _____Years/Años

What previous treatments have you tried?/ ***¿Qué tipo de tratamientos ha seguido?***
□ Medications □ Therapy □ Injections □Other_____

Any previous surgery for this problem?/ ***¿Lo/ La han operado por esta condición médica?***
Please list type and Dates/ ***Por favor, escriba el tipo de operación y la fecha*****:**

_____

Check the symptoms that best describe your problem / ***Seleccione el sintoma(s) que describa su problema***
□ Stiffness / ***Rigidez*** **□ Pain /** ***Dolor*** **□ Instability /** ***Inestabilidad*** **□Numbness / Adormecimiento**
□ Swelling / ***Inflamación*** **□ Other /** ***Otro*****_____**

How severe is the pain? (0 = none/ 10=severe/*severo*)
At Rest /*Al descansar* **0 1 2 3 4 5 6 7 8 9 10**
At its worst/ ***A lo máximo*** **0 1 2 3 4 5 6 7 8 9 10**
Do you have pain at night? /*¿Siente dolor de noche?* **□Yes □No**
Does it wake you from sleep? / ***¿Lo/ La despierta?*** **□Yes □ No**

What makes your problem better? / ***¿Qué mejora sus síntomas?*****_____**
What makes it worse? / ***¿Qué empeora sus síntomas?*****_____**
What are you current limitations? / ***¿Cuáles son sus limitaciones?*****_____**

Are you currently working/*¿Está usted trabajando?* □ Yes/Sí □ No/No □ □Retired/*Retirado*
If yes, at full capacity? ***¿Trabajo de tiempo completo?*** **□ Yes/Sí □ No/No**

Past Medical History: Do you have or are you being treated for, any of the following:
Historia Médica: ¿Tiene o ha sido tratada(o) por lo siguiente?

Medical History/ ***Historia Médica***	**Yes**	**No**	**Please Describe**
Arthritis/ ***Artritis***			
Bleeding,clotting disorder/*Sangramiento*			
Cancer			
Diabetes			
Heartburn; reflux; ulcers/ ***Indigestión-acidez***			
Heart problems /*Problemas del corazón*			
Hepatitis___ (please specify type)			
High Blood Pressure/*Presión alta*			
Kidney Disease/*Enfermedad de los riñones*			
Lung disease;Asthma;emphysema/ ***Pulmones;asma***			
Stroke/*Derrame*			
Thyroid disease/ ***Tiroides***			
Other (specify)/ ***Otro***			

New/Updating Patient Form

Are you pregnanat?/ ***¿Está usted embarazada?***			
Are you HIV positive?/ ***¿Está usted con VIH?***			

Current Medications/ ***Medicamentos actuales***

_____
_____
_____
_____

Allergies: □ No Known Drug Allergies □ Penicillin □ Sulfa □ Iodine □ Radiologic Dyes □ Latex □ Soy □ Shellfish
□ Other:_____

Consent for Orthopedic Associates, USA to obtain your medical history and to use ePrescribing as the means to send certain medication to the pharmacy of your choice.

ePrescribing is defined as a physician's ability to electronically send and accurate, error free, and understandable prescription directly to a pharmacy from the point of care.
The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefic transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with the information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notifications** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Orthopedic Associates, USA can request and use your prescription medication history from third party pharmacy benefit payors for treatment purposes.
Understanding all of the above, I hereby provide informed consent to Orthopedic Associates, USA to enroll me in the ePRescribe Program.

I consent for OAUSA to obtain up to 13 months of my medication history. ____Yes ____No

Patient name (PRINT): _____
Pharmacy name and phone number: _____
Signature of patient or guardian: _____ Date: _____
Previous Surgeries: □ NONE
□Yes/Sí (please list): _____
_____
_____

Have you or a family member had complications from anaesthesia? □ No □Yes (explain):_____

Family History: (Check all that apply)
□ Heart Disease □ Stroke/TIA □ Diabetes □ Gout □ Arthritis (type):_____Cancer(type):_____
□**Other**_____

Do you have any children? / *¿Tiene hijos?* □ Yes / *Sí* □ No / *No* **How many?** / *¿Cuántos?*_____

Do you smoke or use tobacco? / ¿Fuma? □ No / *No* □ Cigarettes_____ □ Cigars □ Pipe □ Chewing Tobacco
If Yes, **How many a day? /** *¿Cuántos por día?* **____How many years /** ¿Cuántos años? **_____ Quit on_____**

Do you drink alcoholic beverages?/ *¿Bebe alcohol?* □ **No** □ **Yes**
If yes, then: □ Socially □ Rarely □ Daily _____drinks per week)

Do you use recreational drugs? / *¿Usa otras drogas?* □ **No** □ **Yes**
If yes, what kind?/ *¿Qué tipo?* **_____**

New/Updating Patient Form

Review of Systems/ *Revisión de sistemas*

Do you have or have you had any of the following symptoms?/ *¿Tiene o ha tenido usted alguno de los siguientes síntomas?*

	Yes	No		Yes	No
Constitutional/ *Síntomas generales:* Fever/ *Fiebre* Chills/ *Escalofríos* Headache/ *Dolor de cabeza* Other/ *Otro:*			**Integumentary**/ ***Cardiovascular:*** Skin Rash/ *Erupción de la piel* Boils/ *Ampollas* Presistent Itch/ *Picazón persistente* Other/ *Otro*		
Eyes/ *Ojos*: Blurred Vision/ *Visión nublada* Double Vision/ *Visión doble* Pain/ *Dolor* Other/ *Otro:*			**Muscular Skeletal/ *Esquelético muscular:*** Joint Pain/ *Dolor articular* Neck Pain/ *Dolor de cuello* Back Pain/ *Dolor de espalda* Other/ *Otro:*		
Allergic/ *Alergias:* Hay Fever/ *Fiebre del heno* Drug Allergies/*Alergias a ciertos medicamentos* Other/ *Otro:*			**Ear/Nose/Throat/Mouth/ *Oído/Nariz/Garganta/Boca*:** Ear Infection/ *Infección de oído* Sore Throat/ *Dolor de garganta* Sinus Problem/ *Sinusitis* Other/ *Otro:*		
Neurological/ *Neurológico:* Tremors/ *Temblores* Dizzy Spells/ *Mareos* Numbness-Tingling/ Ador*mecimiento-hormigueo* Other/ *Otro:*			**Genitourinary/ *Genitourinario:*** Urine retention/ *Retención de orina* Painful Urination/ *Orina dolorosa* Urinary Frequency/ *Orina frecuentemente* Other/ *Otro:*		
Cardiovascular/ *Cardiovascular:* Chest Pain/ *Dolor de pecho* Varicose Veins/ *Venas varicosas* High Blood Pressure/ *Presión alta*			**Respiratory/ *Respiratorio:*** Wheezing/ *Silbidos en el pecho* Frequent Cough/ *Tos frecuente* Shortness of breath/ *Falta de aire* Other/ *Otro:*		
Endocrine/ *Endocrina:* Excessive thirst/ *Sed excesiva* Too Hot-Cold/ *Mucho frío-calor* Tired-Sluggish/ *Cansancio* Other/ *Otro:*			**Hematologic/ Lymphatic/ *Hematológico/ Linfático:*** Swollen Glands/ *Glándulas inflamadas* Blood Clotting Problem/ *Coágulos sanguíneos* Other/ *Otro:*		
Gastrointestinal/ *Gastrointestina*l: Abdominal Pain/ *Dolor abdominal* Nausea-Vomiting/ *Náuseas-vómitos* Indegestion-Heartburn/ *Indigestión-acidez* Other/ *Otro:*			**Psychologic/ *Psicológico:*** Are you unhappy with your life?/ *¿Está usted contento/a con su vida?* Do you feel severely depressed?/ *¿Está usted sumamente deprimido/a?* Have you considered suicide?/ *¿Ha considerado el suicidio?*		

New/Updating Patient Form

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Orthopaedic Associates USA to furnish medical care and treatment to_____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party (Signature) _____ Date: _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Orthopaedic Associates USA. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party (Signature) _____ Date: _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when their services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ORTHOPAEDIC ASSOCIATES USA.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize Orthopaedic Associates USA, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee up to the state maximum legal limit (plus any applicable sales tax). Please note the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that ORTHOPAEDIC ASSOCIATES USA cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: ORTHOPAEDIC ASSOCIATES USA will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operation. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help your better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

New/Updating Patient Form

NO SHOW POLICY

Please be advised that Orthopaedic Associates, USA has a "No Show" Policy. This means that if you do not keep your appointment OR cancel your appointment within 24 hours of the scheduled time, a $50.00 charge will be incurred.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party (Signature) _____ Date: _____

Witness/Center Representative _____ Date: _____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:
* basis for planning your care and treatment
* means of communication among the many health professionals who contribute to your care
* legal document describing the care you received
* means by which you or a third party payer can verify that services billed were actually provided
* a tool in educating health professionals;
* a source of data for medical research;
* a source of information for public health officials charged with improving the health of the nation;
* a source of data for facility planning and marketing and
* a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:
* ensure its accuracy
* better understand who, what, when, where and why others may access your health information
* make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:
* request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
* obtain a paper copy of the notice of information practices upon request
* inspect and copy your health record as provided for in 45 CFR 164.524
* amend your health record as provided in 45 CFR 164.528
* obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request communications of your health information by alternative means or at alternative locations
* revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:
* maintain the privacy of your health information
* provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

New/Updating Patient Form

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've provided to the office. We will not use or disclose your health information without your authorization, except as described in this notice.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: 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.

Fund Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

Effective Date: _____

For Office Use Only

New/Updating Patient Form

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

o Individual refused to sign
o Communications barrier prohibited obtaining the acknowledgement
o An emergency situation prevented us from obtaining acknowledgement
o Other (Please Specify): _____

REFERRAL POLICY

The purpose of this notice is to inform you of our office policy regarding referrals. If your plan requires that you obtain a referral for specialist services, it is your responsibility to do so. We do not contact the primary care physician (PCP) for referrals. If you present to the office without a referral you have the option of paying out of pocket or rescheduling your appointment until you have obtained a referral.

For your convenience, we will accept faxed referrals. However, it is the patient/parent/guardian's responsibility to ensure that the referral is received in the office prior to the appointment. Please feel free to call our office to verify that they referral has been received before arriving to our office if the referral is being faxed. We will not be responsible for referrals that are expired or otherwise invalid. Please request a copy of your referral if one has not been provided to you to enable you to track when a referral is needed. Please advise our office immediately of any changes in your insurance policy as this may void any referrals on file and may result in unnecessary out of pocket expenses to you. If you need assistance in understanding your insurance policy, please see one of our administrative staff members or management and we will gladly assist you.

I ,_____, have read and understand the above policy

Signature:_____Date:_____

CONTRACT FOR PRESCRIPTION / CONTROLLED SUBSTANCE MEDICATION

Controlled substance medications (narcotics, tranquilizers, and barbiturates) and all prescription medications can be very useful in the treatment of pain. Unfortunately, they also have a high potential for abuse and misuse and are closely supervised by the local, state and federal governments.

I agree to enter into the following contract with the health care givers of Orthopaedic Associates U.S.A.:

1 - I am responsible for my controlled substance and all prescription medications. If the prescription or medication is lost, misplaced or stolen or I use it sooner than prescribed, I understand that it will not be replaced.

2 - I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from Orthopaedic Associates U.S.A. The exception would be if I were hospitalized and under the care of another physician.

3 - Refills of controlled substance and all prescription medication:

A. Will be made during office hours only, 8:30 a.m. to 5:00 p.m., Monday through Friday. Refills will not be made at night, on holidays, or weekends.

New/Updating Patient Form

B. Will not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

C. Will not be made as an "emergency". I will call at least 12 to 24 hours ahead if I need assistance with a controlled substance and prescription medication.

D. I understand that if I violate any of the above conditions, my relationship with Orthopaedic Associates U.S.A. may be terminated. I understand that, I may be reported to the Drug Enforcement Authorities, other physicians and local medical facilities.

_____ _____

Patient's Name – PRINT Patient's Signature

_____ _____

Witness Date

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Last **First** **Middle**

Home Address: _____

Home Telephone:_____ _____ **Date of Birth:** _____**Social Security Number:** _____

Specify Information to be Disclosed/Brief Description of PHI Disclosed: (Check one, or all that apply)

☐ Face sheet
☐ History and Physical
☐ Purpose or use of Disclosure
☐ Lab test results, specify: _____
☐ Radiology test results, specify: _____
☐ Discharge Summary ☐ Continuity of Care
☐ Consultation ☐ Personal
☐ Entire Medical Record ☐ Itemized bill or billing information ☐ Legal
☐ Emergency Room Record ☐ Discharge Medication List ☐ Insurance

☐ Other, specify: _____

Dates of service needed: _____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization: (May waive this section of not pertinent)

☐ Mental Illness _____
☐ Developmental Disability _____
☐ Psychotherapy Notes _____
☐ HIV/AIDS Testing or Treatment (regardless of result) _____
☐ Venereal Disease _____
☐ Abuse of an Adult with a Disability _____
☐ Sexual Assault _____
☐ Child Abuse or Neglect _____
☐ Other:_____ _____

RECIPIENT: Name of the person or class of persons to who Orthopaedic Associates USA may disclose my health information:
Name:_____ Address: _____

TERM: This authorization will remain in effect:
☐ From the date of this Authorization until the_____day of_____, 20_____.
☐ Until Covered Entity fulfills this request.
☐ Until the following event occurs:_____

PURPOSE: I authorize Orthopaedic Associates USA to use or disclose my health information (including the highly confidential I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization:
_____.

New/Updating Patient Form

I understand that once Orthopaedic Associates USA discloses my health information to the recipient, Orthopaedic Associates USA cannot guarantee that the recipient
will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclose of my health information.
I understand the Orthopaedic Associates USA may, directly or indirectly, receive remuneration from a third party in connection with the use or disclose of my health information.
I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Orthopaedic Associates USA; except, however, if my treatment at Orthopaedic Associates USA is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Orthopaedic Associates USA may refuse to treat me if I do not sign this Authorization.
I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Orthopaedic Associates USA Privacy Office at the address listed below. The revocation will be effective immediately upon Orthopaedic Associates USA receipt of my written notice, except that the revocation will not have any effect on any action taken by Orthopaedic Associates USA in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Orthopaedic Associates USA to use or disclose mv health information in the manner described above.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Orthopaedic Associates USA to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures: Signature of

_____
Personal Representative

_____ _____
Description of Authority Date

Orthopaedic Associates USA □350 North Pine Island Road, Suite 200□Plantation, FL 33324
□(954) 476 8800 (office) / (954) 476 1362 (fax)