

# Southern Orthopedic Specialists, P.A.

Samuel L. Combs III, M.D. Thomas C. Mitchell, M.D. Cory R. Gaiser, D.O. Michael C. Noble, M.D.  
David R. Dietrich, M.D. Rafael M.M. Williams, M.D. Steven W. Malik, M.D. James C. McLoughlin, M.D.

PLEASE PRINT

Phone: \_\_\_\_\_ (H)

Date: \_\_\_\_\_ (W)

(If none, number of nearest phone.)

Patient Name: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial) (Age) (Birthdate)

Guardian (If Applicable): \_\_\_\_\_

Sex:  M  F  Single  Married  Widowed  Divorced Soc. Sec. No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Name of friend or relative at different address (Phone Number)

Do you currently reside in a nursing home?  Yes  No

If yes, name of facility: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscribers SS# \_\_\_\_\_ Patient Relationship to subscriber: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Patient Relationship to subscriber: \_\_\_\_\_

**Tertiary Insurance:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscribers SS# \_\_\_\_\_ Patient Relationship to subscriber: \_\_\_\_\_

Are you here due to an auto accident?  Yes  No If so, Date of Accident: \_\_\_\_\_

Are you here due to an accident at work?  Yes  No If so, Date of Accident: \_\_\_\_\_

Description of accident or onset of symptoms: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Your Drugstore: \_\_\_\_\_  
(Name) (Phone Number)

Name of Private Doctor or Clinic: \_\_\_\_\_

Referred By: (Above?) \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of Southern Orthopedic Specialists, P.A. Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
*Patient Printed Name*

\_\_\_\_\_  
*Patient or Legal Guardian Signature*

\_\_\_\_\_  
*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

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

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Employee Printed Name*

\_\_\_\_\_  
*Title*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices  
*This form does not constitute legal advice and covers only federal, not state, law.*



**SOUTHERN  
ORTHOPEDIC  
SPECIALISTS, P.A.**

**Samuel L. Combs, III, M.D.**  
*Hip and Knee Replacement*  
*Board Certified*  
(850) 785-6029

**Thomas C. Mitchell, M.D.**  
*Pediatric Orthopedics*  
*Sports Medicine*  
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(850) 785-0095

**Rafael M. M. Williams, M.D.**  
*Hand - Wrist and*  
*Shoulder-Elbow Surgery*  
*Board Certified*  
(850) 522-HAND

**Steven W. Malik, M.D.**  
*Sports Medicine*  
*Board Eligible*  
(850) 785-0073

**James C. McLoughlin, M.D.**  
*Spine Surgery*  
*Orthopedic Surgery*  
*Board Certified*  
(850) 785-8480

**1827 Harrison Avenue**  
**Panama City, Florida 32405**  
**(850) 785-4344**

Dear Patient,

Thank you for choosing Southern Orthopedic Specialists, P.A. for your medical needs. We pledge to give you the best medical care possible and treat you with friendliness, respect, and dignity. We appreciate your business.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Sincerely,

  
Chief Financial Officer

Patient / Legal Guardian Signature: \_\_\_\_\_

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

**FINANCIAL PAYMENT POLICY**  
**Of the office of**  
**Southern Orthopedic Specialists, P.A.**

1. **REGARDING INSURANCE:** The doctor's service is provided directly to you and you are responsible for payment of services rendered. Our office participates with Medicare and many other insurance companies. Should your insurance coverage be with one or more of these companies we will, as a courtesy to you, bill your insurance along the guidelines of our contract. However co-payment, deductibles, and non-covered charges are the responsibility of the patient and payment is expected at the time services are rendered.
2. **SPECIAL ARRANGEMENTS:** There are time when making payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our billing staff or manager as soon as possible.
3. **COLLECTION FEES:** In consideration of the services to be rendered to the patient, I individually promise, whether signing as the patient, patient's agent, or as guarantor, to pay the account of Southern Orthopedic Specialist not later than the time treatment is rendered, unless specific account payment arrangements have been previously approved by SOS. Should the account be referred to an attorney or other third party collections, the undersigned shall pay reasonable attorney fees, third party collection fees and collection expenses. I waive notice of demand as a prerequisite to the commencement of legal proceedings for medical charges. No delay or omission by the hospital shall be considered a waiver of any right. I agree that venue in any action brought against me for medical charges shall be in Bay County, Florida. The law prescribes all delinquent accounts bear interest at the highest legal rate or in the event no maximum rate, at eighteen percent (18%) per annum.

Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should have further questions or comments, please contact our billing staff or manager.

I hereby understand the financial policy of this office: \_\_\_\_\_  
PATIENT NAME (Please Print)

\_\_\_\_\_  
PATIENT or LEGAL GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE

.....

**MEDICARE/ALL INSURANCE AUTHORIZATION**

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the provider for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim(s). If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms of electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Insurance companies.

\_\_\_\_\_  
PATIENT or LEGAL GUARDIAN'S NAME (PRINT)

\_\_\_\_\_  
PATIENT or LEGAL GUARDIAN'S SIGNATURE



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**GENERAL PATIENT/PHYSICIAN AGREEMENT**

Please read the following paragraphs, initial below each paragraph that you have read, understand and agree to the same.

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints. Appropriately, the patient understands and authorizes treating physician and/or staff to communicate with previous physicians by any method, to include a "physician only" web site and/or any physician that can assist with the care of the patient as long as confidentiality is kept at the professional level. I have read, understand, and agree with the above.

Patient/Legal Guardian Initials: \_\_\_\_\_

The patient understands that he or she is not required to use treating physician or any other physician employed by or under the direction of this facility or practice for general healthcare and/or surgery. The patient understands medicine is not an exact science and there is risk involved in any medical procedure. The patient understands he or she is being treated at his or her own risk. It is further understood that in the event of any controversy or dispute which might arise between the patient and the physician, regardless of whether the dispute concerns the medical care rendered by the treating physician or any manner whatsoever, then the patient agrees that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration code, Chapter 682 & 684, Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trials by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction. I have read, understand and agree with the above.

Patient/Legal Guardian Initials: \_\_\_\_\_

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician's care and/or facility thus releasing the treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illnesses and misusing medications. I have read, understand and agree with the above.

Patient/Legal Guardian Initials: \_\_\_\_\_

I \_\_\_\_\_, as the patient/guardian, have read and understand all paragraphs above by initialing below each paragraph. I have agreed to abide by their content by signing below.

In witness whereof, I have set my hand this date \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Physician or Authorized Agent

\_\_\_\_\_  
Patient or Legal Guardian Signature

# **SOB**

## **SOUTHERN ORTHOPEDIC**

### **SPECIALISTS, P.A.**

**Samuel L. Combs, III, M.D.**  
*Hip and Knee Replacement*  
*Board Certified*  
(850) 785-6029

**Kenneth W. Smith, D.O.**  
*Musculoskeletal Trauma*  
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*Shoulder-Elbow Surgery*  
*Board Certified*  
(850) 522-HAND

**Joseph P. Grace, M.D.**  
*Joint Replacement*  
*Board Certified*  
(850) 769-3574

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**Panama City, FL 32405**  
**(850) 785-4344**

### **PERMISSION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_

I give permission for the following:

\_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

to speak with my Doctor/Doctors at Southern Orthopedic  
Specialists, P.A. concerning my medical condition.

I understand that I have the right to revoke this authorization at any  
time. I understand that if I revoke this authorization I must do so in  
writing. I understand that this authorization expires two years from  
date signed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## MEDICAL HISTORY

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DATE FORM FILLED OUT \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

NOTE: Please fill out and bring to your first appointment. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

### 1. MEDICATIONS

<u>Name</u>	<u>Strength</u>	<u>Dosage</u>	<u>Prescribing Dr.</u>

### 2. ALLERGIES - Please circle any medications to which you are allergic:

Penicillin    Sulfa        Codeine        Morphine        Demerol        Aspirin        Iodine  
 Tetanus        Horse serum        Latex Allergy        Tape

Please list any substance to which you are allergic, not covered above.

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### 3. HABITS

- Smoking -
1. I do not smoke and have never smoked \_\_\_\_\_
  2. I do not smoke now but used to smoke \_\_\_\_\_  
     Packs per day \_\_\_\_\_  
     How many years \_\_\_\_\_  
     Date you quit \_\_\_\_\_
  3. I presently smoke \_\_\_\_\_  
     Packs per day \_\_\_\_\_  
     How many years \_\_\_\_\_

- Alcohol -
1. Do you consume alcoholic beverages now?    Yes    No
  2. Do you have a "drinking" problem now?    Yes    No
  3. Have you ever had a "drinking" problem?    Yes    No

- Drugs -
1. Do you use recreational drugs now?    Yes    No    (Marijuana, Cocaine, LSD, Crack)
  2. Have you ever used recreational drugs?    Yes    No
  3. Do you use sleeping pills, tranquilizers, or pain meds on a regular basis?    Yes    No

4. SURGERY

List operations you have had:

<u>Type</u>	<u>Date</u>	<u>Hospital</u>	<u>Surgeon</u>	<u>Complications</u>

5. ILLNESSES

<u>Diagnosis</u>	<u>Date</u>	<u>Hospital</u>	<u>Doctor</u>

6. ACCIDENTS AND INJURIES

<u>Type</u>	<u>Date</u>	<u>Hospital</u>	<u>Doctor</u>

7. REVIEW OF SYSTEMS — Answer YES if you currently have or have ever had the following.

Problem	Yes	No	Problem	Yes	No
Glaucoma			Stomach Ulcers		
Poor Eyesight			Jaundice		
Poor Hearing			Hiatal Hernia		
Nosebleeds			Reflux		
Hoarseness			Intestinal Bleeding		
Difficulty Swallowing			Hernia		
Neck Pain			Diverticulitis		
Frequent Headaches			Hemorrhoids		
Thyroid Disease			Bloody Stools		
Pneumonia			Hepatitis		
Pleurisy			Indigestion		
Bronchitis			Gallbladder Problems		
Asthma			Colitis		
Hay Fever			Appendicitis		
Shortness of Breath			Gastritis		
Chest Pain			Bladder Control Problems		
Pulmonary Embolus			Kidney Stones		
Persistent Cough			Kidney/Bladder Infections		
Heart Attack			Prostate Problems		
High Blood Pressure			Frequent Infections		
Heart Valve Disease			Cancer		
Irregular Heartbeat			Unexplained Weight Loss		
Heart Failure			Diabetes		
Heart Murmur			Chronic Back Pain		
Circulatory problems			Sciatica		
Varicose Veins			Polio		
Phlebitis			HIV Positive		
Anemia			AIDS		
Blood Clot in Legs			Psoriasis		
Epilepsy			Skin Problems		
Dizziness			Gout		
Stroke			Osteoarthritis		
Nervous Breakdown			Rheumatoid Arthritis		
Mental Illness			Rheumatic Fever		
Insomnia			Sleep Apnea		
Concussion			<b>OTHER:</b>		
Meningitis					
Depression					

8. LIST DOCTORS TREATING YOU NOW OR IN THE LAST FIVE YEARS:

Doctor	Problem

9. FAMILY HISTORY - Has any immediate blood relative ever had: CHECK IF YES

Cancer \_\_\_\_\_ Heart Disease \_\_\_\_\_ Mental Illness \_\_\_\_\_ Congenital Deformities \_\_\_\_\_  
 Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_  
 Other \_\_\_\_\_

10. SOCIAL HISTORY - Present occupation \_\_\_\_\_ Number of children \_\_\_\_\_

Married \_\_\_\_\_ I live alone \_\_\_\_\_  
 Single \_\_\_\_\_ I live with someone who can care for me \_\_\_\_\_  
 Widowed \_\_\_\_\_ I live with someone who is unable to care for me \_\_\_\_\_  
 Divorced \_\_\_\_\_ I live alone but have friends/family who can care for me \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on January 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**(a) Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$ 1.00 for each page which includes the time required to locate and copy your health information.

**(b) Right to Request Restriction of PHI:** You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where "the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

HIPAA Notice of Privacy Practices 2010

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**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

## **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$ 1.00 for each page which includes the staff time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**Breach Notification Requirements:** Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

## **QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

## **HOW TO CONTACT US**

Practice Name: Southern Orthopedic Specialists, P.A.

Privacy Officers: Becky Carreira & Sherri Sullivan

Telephone: (850) 785-4344

Fax: (850) 785-6568

Address: 1827 Harrison Avenue, Panama City, FL 32405

Email: [info@southernorthopedic.com](mailto:info@southernorthopedic.com)

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**1. INTRODUCTION**

Welcome to Southern Orthopedic Specialists, P.A. This pamphlet provides information that we hope will foster a pleasant and effective relationship between patient and physician and contribute to better understanding of how to serve you, the patient. If you have further questions, please do not hesitate to ask any member of our staff.

**2. APPOINTMENTS**

- A. If you are unable to keep your appointment please call the office and cancel it at least 24 hours in advance.
- B. The physicians and staff work hard to see patients on time. If you have to wait to be seen it is for an unavoidable reason. We are obliged to see emergencies and patients referred on an urgent basis by other physicians. Some patients require an unexpected amount of time due to unforeseen complications or problems. For these reasons, we are occasionally behind schedule. We ask for your understanding in those situations.
- C. Please complete the information sheet and medical history forms and bring it with you at the time of your first visit.

**3. CHARGES**

- A. Charges made for surgical procedures cover post-op office visits for a period of time determined by your insurance company, varying from 7 to 90 days. The surgery charges do not cover x-rays or cast changes made relative to the surgery.
- B. Charges for fracture treatment cover all office visits related to the fracture for a period of time determined by your insurance company, varying from 7 to 90 days. The fracture charges do not cover x-rays or cast changes.
- C. If it is determined that you are going to need to have surgery, our office will call your insurance company to determine what portion of the surgery your insurance will cover. Someone from our insurance department will then contact you and inform you of approximately how much you will owe the physician. Patients will be expected to pay their portion of an elective surgery prior to it being performed. Self-pay patients will also be responsible for paying a portion of their surgery in advance as well.

**4. BILLING**

- A. Statements are sent out at the end of each month.
- B. A statement will be sent to you even though your insurance company may be responsible for the payment. This allows you to keep track of how well your insurance company is serving you. Your statement will reflect the date on which your charges are filed to your insurance company. This will give you some idea as to how long it takes your insurance company to process your claim.

**5. TREATMENT POLICIES**

- A. Most orthopedic problems can be treated by non-surgical means and every such means available that is indicated in the treatment of your particular illness will be exercised before surgical treatment is recommended.
- B. Satisfactory results are not guaranteed for any type of surgical procedure as there is not a single operation that is 100% successful. Results of surgery are affected by genetics, life style and patient cooperation as well as surgeon skill. Medicine is also not an exact science. If surgery is recommended to you, the probability of a successful outcome will be explained to you. If you do not understand the reasons for the surgical procedure, its chances of success, or its possible complications, please ask us. Also, do not hesitate to ask us the charge for a particular operation if you desire that information.
- C. An adult must accompany all patients under 18 years of age.

**6. MEDICATIONS**

Narcotic medications are prescribed only for patients in severe pain. Narcotic medications are not kept in the office. Requests for prescription refills should be made before 3:00p.m. Requests received after 3:00p.m. will be addressed the next business day. We do not prescribe prescriptions after business hours, on weekends or holidays.

**7. MEDICAL RECORDS**

- A. Medical records will be sent to your insurance companies, attorneys, other physicians, etc. upon request of that person in writing.
- B. The patient must sign a statement authorizing the release of information before this information can be sent to anyone.

**8. X-RAYS**

X-rays that are taken in our offices are part of the patient's original medical record. Therefore, the original x-ray may not leave this office. If you would like a copy of your x-rays, you must request them at least one day in advance, so our x-ray technician will have time to prepare the copies. There is a charge of \$5 per sheet of film. Our x-ray technicians try to put as many images as possible on one sheet of film to keep the cost to you at a minimum. Patients must sign a statement authorizing the release of the x-ray since it is part of the medical record.

**9. DME**

In an effort to serve you faster and more thoroughly we have an on site durable medical equipment department. For those patients that are in need of a brace and have a qualifying insurance policy we carry the most commonly used orthopedic braces. To insure that you are getting a quality brace we have a no return policy on all of our DME.

## **FINANCIAL PAYMENT POLICY**

In our effort to provide quality health care to our community, it is important to establish a clear credit policy to avoid any misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. All accounts are payable at the time of service. We accept VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS for your convenience. Payment arrangements are available through our trained Insurance Specialists in accordance with our Credit Guidelines. If you feel that you will not be able to pay your bill, please inform one of our receptionists so that a representative in the billing department can make payment arrangements.

As a service to our patients, we will bill your primary and secondary insurance carriers provided you supply the name, address, group and ID# and the name of the policyholder. If you prefer to bill your own insurance, we will furnish you with a complete itemized statement. We do not negotiate disputed claims with your insurance company. If you have questions regarding your coverage or any special arrangements, please contact your insurance carrier directly.

All patients will be required to sign an insurance release form that allows us to file their insurance to their carriers. Patients will also be required to sign a statement stating that they have read our Financial Payment Policy and will be responsible for their bill.

### **A. Patient Responsibility, with Insurance**

1. Co-pays are due at the time of visit
2. Deductibles must be paid at the time of service, if not paid prior to your visit.
3. For surgery, arrangements for patient responsibility must be made in advance. Of course emergency surgery will be handled in manner applicable to the need.
4. All insurance payments will be monitored closely to assist you in experiencing the highest possible payout under your plan.
5. Portions not paid by your insurance carrier will become your responsibility.

### **B. Patient Responsibility, without Insurance**

1. Payment is due upon receipt of the service. We accept VISA, MASTERCARD, DISCOVER, or AMERICAN EXPRESS for your convenience.
2. When considering payment arrangements, the following guidelines will be used:
  - a. A Patient Responsibility Agreement form must be on file.
  - b. The full balance must be arranged at the time of the first statement.
  - c. All balances must be cleared within 12 months from the date of service.
  - d. A Minimum monthly payment will be required.
  - e. A Financial Agreement may be required when circumstances require arrangements beyond our standard guidelines.
  - f. When surgery is scheduled, financial arrangements must be completed prior to the date of surgery.

### **C. Managed Care**

Many insurance companies now have PPO and Participating Physician fee schedules. Contracts are negotiated on an annual basis. If you are part of one of these plans, please be sure to verify whether Southern Orthopedic Specialists, PA. participates with your particular plan. We also try to verify this information and alert you prior to your visit if at all possible, however, it is ultimately the patient's responsibility. If your managed care plan requires a referral from your primary care physician (PCP), you are responsible for obtaining it prior to making your appointment. If you do not have a referral by the time of your visit, you will be asked to sign a disclaimer and the charges for the visit will be your responsibility.

### **D. Worker's Compensation Claims**

If your visit involves a worker's comp claim, notify the receptionist immediately. Authorization must be obtained prior to being seen. Please indicate if this is a new claim, open claim or if it has been some time since you spoke with your claims adjuster. Any charges not accepted as part of your claim become your responsibility.

### **E. Motor Vehicle Accident Claims**

All motor vehicle accidents are billed to your auto insurance carrier. Once PIP is exhausted, the balance becomes your personal responsibility. We will bill your primary health insurance carrier, if applicable. Many times auto insurance will pay 80% of the charges. Patients will be responsible for the remaining 20%. Payment will be expected within our usual credit guidelines.

### **F. Medicare**

As Medicare Participating Physicians, we accept the Medicare fee schedule. The patient is responsible for the annual deductible and 20% coinsurance at the time of service.

### **G. Medicare and Supplement**

As Medicare Participating Physicians, we accept the Medicare fee schedule. After Medicare pays, your supplement will be filed. Only one Medicare supplement will be filed.

### **H. Medicaid**

Southern Orthopedic Specialists, PA. is not a participating provider for Medicaid. We are not able to bill Medicaid and any patient with Medicaid insurance is considered self pay. Payment is due at time of service.

### **I. Disability Insurance**

Disability insurance forms will be completed for a small fee. Patients are asked to complete their portion of the form and leave it with the office. The forms will be mailed directly to the insurance company with copies available, on request. Please bring the forms in early to allow for adequate processing time.

Thank you for allowing us to serve you. If you need any assistance, please do not hesitate to ask. We are here to serve you.