Center for Orthopaedic Injuries & Disorders

Theodore P. Vlahos M.D., P.A.

Certified, American Board of Orthopaedic Surgery

Theodore P. Vlahos, M.D.

Dear Patient,

We know that filling out this long patient information packet is a lot of work for you and may be difficult. However the more information you give us, the better we can help you.

You **must** bring the following to your initial appointment to avoid delays:

- **MRI and X-ray films and reports** taken since your accident
    - If films are not brought in, new x-rays may need to be done in order to provide the most thorough evaluation.
- **Diagnostic Reports** such as nerve tests, procedure notes, etc.
- **Questionnaire**
    - Please complete thoroughly, leaving **no** questions blank!
- **Paperwork** dated for the date of your appointment
- **Photo ID**
- **All insurance cards**

Please arrive 30 minutes prior to your scheduled appointment time.

Thank you!

31581 U.S. 19 North • Palm Harbor, Florida 34684

Tel: (727) 772-0819 • Fax: (727) 772-8430

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Theodore P. Vlahos, M.D.

Please Let Us Know the Best Way To Contact You

Name: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

Cell Carrier: ______________________________

E-Mail: ______________________________

I hereby authorize Theodore P. Vlahos, M.D., P.A. to send me reminder texts and/or e-mails.

______________________ ______________
Signature Date

Cancellation Policy

I, ______________________________ agree to call at least 24 hours before my appointment date to cancel or reschedule my appointment. I understand that non-compliance of this agreement will result in $120.00 fee.

______________________ ______________
Signature Date

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NEW PATIENT INFORMATION

NAME OF PATIENT: ______________________ AGE:______ DATE OF BIRTH:______________
SEX: M _____ F _____ MARITAL STATUS :(circle) S M D W SS#:______________________
HOME PHONE: ________________________ WORK PHONE: ____________________
CELL PHONE: ________________________ E-MAIL:__________________________
IF PATIENT IS A MINOR, PARENT'S NAME: _________________ PARENT SS #:___________
HOME ADDRESS: ______________________ CITY ________________ ST ____ ZIP ________
MEDICAL INSURANCE: ___________________________ ID NUMBER: ______________
SECONDARY INSURANCE: ________________________ ID NUMBER: ______________
OCCUPATION: ____
EMERGENCY CONTACT:_____________________________ PHONE:______________
WHO IS YOUR PRIMARY PHYSICIAN: _________________ PHONE: ______________
WHAT OTHER DOCTORS DO YOU SEE:_______________________________________
WHAT INJURY OR PROBLEM ARE YOU HERE FOR TODAY: _________________________

____

IS THIS A WORK RELATED INJURY: YES _____ NO _____ DATE OF INJURY: ____________
DURATION OF PROBLEM:____

CURRENT MEDICAL PROBLEMS OR CONDITIONS: ____________________________

____

____

HISTORY OF MAJOR MEDICAL PROBLEMS (such as cancer, etc.): _______________

____

PAST OPERATIONS (include year):____

____

CURRENT MEDICATIONS: ____

ALLERGIES TO MEDICATIONS:____

WHAT DISEASES RUN IN YOUR FAMILY:_______________________________

DO YOU SMOKE:____ HOW MUCH:________ DRINK ALCOHOL:____ HOW MUCH:__________
ANY PAST HISTORY OF TRAUMA, WORK ACCIDENT OR AUTO ACCIDENT (please describe and give year):____

HEIGHT: ________________ WEIGHT: ________________

I authorize the release of any medical or other information necessary to process this claim and payment of medical benefits for services described . I also release medical and other information necessary for the benefit of my medical care to other physicians and providers of medical services.

Signature: ____________________________________ Date:______________________________

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NEW PATIENT INJURY QUESTIONNAIRE

PLEASE FILL IN ALL SPACES, DO NOT LEAVE BLANKS!

NAME: ______________________________ AGE: ________

DATE OF INJURY: ______________ HEIGHT: _____ WEIGHT: _____

1. What type of accident did you have: Car accident, slip and fall, work, or other?

____.

Briefly describe how the accident occurred. ______________________________.

____.

2. If this was a motor vehicle accident:

A. Were you the driver? _______ If not, where were you sitting? __________
B. Were you wearing your seatbelt? _________ Did your airbags deploy? ______
C. Did your head hit anything? ___________ If yes, what? ___________
D. Did you lose consciousness? ______________________

3. Did you go to the emergency room? _____ If yes, which one? ____________
A. When ____________
B. How did you get there? ____________ On a backboard? __________

4. What parts of your body were hurting right after the accident? (within six hours).

____

5. What treatment have you received until now? Please list **ALL** doctors, chiropractors and any physical therapy. **ALSO**, please list any **MRIs, x-rays** or **other studies** you have had. ____

____.

6. Are you represented by an attorney? __________ If so, please give the name, address and phone number. ______________________________

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IN ORDER TO BEST DESCRIBE YOUR PAIN, WE WILL USE A PAIN SCALE FROM 0-10. NOTE: The severity does not depend on how long the pain lasts.

0 = no pain
1, 2, 3 = mild pain
4, 5, 6 = moderate pain
7, 8, 9 = severe pain
10 = torture, childbirth contractions, kidney stone, severed limb pain

7. HEADACHES

Are you having headaches? _________ Describe them. ____________________

____

Please circle any other associated symptoms such as; nausea, vomiting, flashing lights, dizziness, blurry vision, etc.

Have you felt dizzy, off balance or unsteady since the accident? ________________

How bad are the headaches from 0-10? ______ How often do they occur? __________

How long do they last? ____

Did you have headaches **BEFORE** this accident? If so, how often? ______________

How bad were the headaches, from 0-10 **BEFORE** this accident? ______________

8. JAW

Do you have any jaw pain, clicking or popping? ___________ How bad from 0-10?

__________ If yes, did you have these symptoms **BEFORE** the accident? __________

9. NECK

Do you have neck pain? ____________ Describe the pain. ____________________

____

How often? ________________ Where is the pain? _____________________________

Does the pain travel down into your arms? __________ Which one(s)? ____________

Do you have any numbness or tingling in your arms or hands? ____________________

Where? __________________________

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NECK (CON'T):

Does the pain go into your upper back or shoulder blades? ______________________

How bad is the neck pain from 0-10? ______What makes it feel better?____________

Did you have any neck problems or injuries **BEFORE** this accident? ______________
If so, when? ____
Was your neck hurting **recently BEFORE** this current accident? _______________
How often did your neck hurt **recently BEFORE** this accident? ________________
How bad was your neck hurting from 0-10 **recently BEFORE** this accident: _________

10. SHOULDERS

Do your shoulders hurt? _______________ Which one(s)? ____________________

How bad from 0-10? __________ Do they hurt worse when you raise your arms or use them? ________ Do they make noise? __________________ Do they hurt more at nighttime? _________ Do they feel as if they are coming out of socket? __________

Is this new? ____________ Did you have any shoulder problems **BEFORE** this accident? _______ If yes please explain: ________________________________

How bad was the pain **BEFORE** this accident from 0-10? _________ Are you double jointed anywhere? ______

11. ELBOWS/WRISTS/HANDS

Do you have pain in your elbows, wrists or anywhere in your hands? ____________

How bad is the pain from 0-10? _______ Please describe. _______________________

12. CHEST/RIBS

Do you have any pain in your chest or ribs? ________________________________

Does it hurt to breathe deeply or cough? __________________ Did your chest hit the steering wheel or other object? ____

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13. BACK PAIN

Do you have back pain? ______________ How often? ________________

Where in your back? (Please circle): Upper Middle Lower

What does the pain feel like? (Please Circle): Sharp Dull Stabbing Electric Achy

How bad is the back pain from 0-10? ____________

Does the pain go down your legs or into your buttocks? ________ If yes, describe.

________________________________. Do you have any numbness or tingling in the legs? _________ Does the pain get worse if you cough, sneeze or strain to go to the bathroom? _________ Have you had any loss of control of your bladder, bowels or (men only) erections? ________ What makes your back feel better? ______________________

Did you have any back pain or injuries **BEFORE** this accident? ______ If so, how bad was the pain just **BEFORE** this accident from 1-10? _________ How often was your back hurting in the last few months **BEFORE** this accident: ______________________

14. GROIN

Do you have any groin pain? ________ Describe. ___________________________

15. KNEES

Do you have any knee pain? _________ Which one(s)? ______________________

Did your knees hit the dash, steering column or something else? ___________________

Do they swell up? ____________ Do they make noise? _________

Do they give way?_________ Where is the pain? (front, sides, kneecap, etc.) _________

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KNEES (CON'T):

Have you ever not been able to straighten them out? ___________

Does it hurt to go up or down stairs? _______ Does it hurt to stay seated for a long time? ____________

How bad is the pain from 0-10? _________ Did you have knee problems **BEFORE** this accident? _____If so, how often was it hurting from 0-10 **BEFORE** this accident? _____

16. FEET/ANKLES

Do you have pain in the feet or ankles? _________ Please describe. ____________

Did you have any prior problems, or pre-existing foot or ankle problems **BEFORE** this accident? ____________ If yes, explain: _____________________________________.

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PAST MEDICAL HISTORY

1. Do you have any medical conditions, treated or untreated? _______________ Please list **ALL** ____

____

2. Have you had any previous operations? _________ Please list **ALL** with _________ approximate date ____

3. What medications do you take? Please list **ALL**, including any herbals, vitamins or over the counter medications. ____

____

4. Do you have any allergies to medications? Please list **ALL** ____________________

____

5. Have you had any previous car accidents or work accidents? __________________

What year(s)? ________________________ If yes, please describe any major aches or pains you were having before this accident happened. (Example: back pain, neck pain, etc…) ____

6. Do any major diseases or medical conditions run in your family? Describe.

____

SOCIAL HISTORY

7. Do you use tobacco? _________________ How much? _____________________

8. Do you drink alcohol? _________________ How much? _____________________

9. What is your occupation? ____

Did you miss work after the accident? ___________ How long? _________________
Are you working now? __________________

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REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY PROBLEM IN THE CATEGORIES BELOW? PLEASE DESCRIBE IN DETAIL.

Constitutional: Fevers, chills, weight loss or gain, etc... ____________________

Eyes: ____________________

Ears, nose, mouth, throat: ____________________

Cardiovascular: Heart or blood vessels, high blood pressure, etc... ____________________

____

Respiratory: Breathing problems, asthma, emphysema, etc... ____________________

____

Gastrointestinal: Stomach, intestines, colon, liver problems. Includes ulcers, heartburn, hepatitis, etc... ____________________

Genitourinary: Problems with the kidneys, bladder, prostate, sexual organs, etc. ____________________

____

Musculoskeletal: Problems before this current injury with your bones, muscles, tendons, etc... Include things like fibromyalgia, osteoporosis, arthritis (diagnosed by a doctor) etc... ____________________

Skin or breast problems such as tumors, growths, etc... ____________________

Neurologic: Seizures, brain disorders, nerve problems or damage, carpal tunnel, etc.

____

Psychiatric: ____________________

Endocrine: Problems with the thyroid, parathyroid, adrenals, hormone problems, pancreas, diabetes, etc... ____________________

____

Hematologic/Lymphatic: Problems with your blood cells, anemia, polycythemia, sickle cell, thallasemia, lymph nodes or system, i.e. lymphoma, leukemia, etc... ____________________

____

Allergic/Immunologic: Lupus, rheumatoid arthritis, immune problems, etc... ____________________

____

Other problems not mentioned: ____________________

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AUTHORIZATION TO RELEASE INFORMATION

I do hereby authorize **The Center For Orthopaedic Injuries & Disorders,** its health care providers and employees to release copies of my medical records including all office notes, medical information forms, radiology or laboratory reports and radiology studies to the following:

1) My insurance carrier or its representative.
2) My primary care physician or referring health care professional.
3) My attorney in the case that the injuries being treated are the result of an accident which may be the subject of litigation.
4) Medical consultants involved in the care of my medical conditions or injuries.

In addition, I authorize release of an itemized statement of services rendered to me with regard to my accident or injury in order to process any claim for that I may have in connection with such accident or injury and to pay charges incurred by me as a result of the professional services that I have received. Furthermore, by my signature below, I hereby release **The Center For Orthopaedic Injuries & Disorders**, its providers and employees of any consequences thereof.

AUTHORIZATION FOR INFORMATION

I do hereby authorize all physicians, hospitals, ancillary service centers, other health care providers, attorneys, etc… to release to **The Center For Orthopaedic Injuries & Disorders**, copies of my complete medical records including office notes, reports, consultations, laboratory and radiology reports and studies. I understand that this is to assist in the treatment of my orthopaedic injuries or conditions and that privacy will be respected to the fullest extent possible.

I have read and fully understand the above:

______________________________ Signature

________________ Date

______________________________ Printed Name

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CENTER FOR ORTHOPAEDIC INJURIES AND DISORDERS

AUTHORIZATIONS:

Authorization to pay benefits to provider: I hereby authorize payment directly to The Center For Orthopaedic Injuries & Disorders. If payment is sent directly to me (the patient), I will promptly submit the same to The Center For Orthopaedic Injuries & Disorders.

Authorization to release information: I hereby authorize The Center For Orthopaedic Injuries & Disorders to release any information acquired in the course of my examination or treatment.

Authorization to photocopies: I herby authorize photocopies of this form to be as the original.

One Time Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

I hereby acknowledge I am personally responsible for payment for any and all treatments rendered not covered by a medical insurance plan.

____________________________ ____________________

Patient's Signature Date

____________________________ ____________________

Signature of Parent (if minor) Date

____________________________ ____________________

Witness Date

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PERSONAL INJURY AGREEMENT/WAIVER OF HEALTH INSURANCE

I have been involved in an injury which may involve litigation. I understand that this may create the need for documentation, correspondence, planning, etc. which is greater than for non-litigation related claims. I understand that due to certain complexities or difficulties associated with litigation related claims, many physicians in this area decline to treat such patients. I also understand that if I currently have health insurance benefits such as through Medicare, HMO or PPO, that I have certain rights as a third party beneficiary to obtain healthcare at contracted rates from a willing healthcare provider. I understand that **Dr. Vlahos** and the **Center for Orthopaedic Injuries and Disorders** will not provide services for litigation or potential litigation related claims under any form of health insurance including Medicare, Medicaid, HMOs or PPOs even though they may be listed as contracted providers. Therefore, because of certain specific skills, knowledge and experience held by Dr. Vlahos and the **Center for Orthopaedic Injuries and Disorders,** I hereby knowingly and voluntarily elect to obtain services with them outside of the health insurance system to which I belong and have certain rights. I hereby understand and knowingly agree that **Dr. Vlahos** and the **Center for Orthopaedic Injuries and Disorders** shall have the right not to bill my health insurance, Medicare, HMO, PPO or other, even if they are contracted providers on that plan. I do, therefore knowingly and voluntarily waive all rights to use such health insurance, Medicare, etc. and agree that all providers for the **Center for Orthopaedic Injuries and Disorders** may charge their usual and customary fees for all services provided and may place such charges under a **Letter of Protection**. I further affirm that I have been afforded the opportunity to review the fee schedule for the **Center for Orthopaedic Injuries and Disorders** and agree in advance that such fees are reasonable for the services provided.

In addition, I agree that I, or anyone on my behalf, will not submit my bills to my health insurance without the permission of the **Center for Orthopaedic Injuries and Disorders**. I understand and agree that I am ultimately responsible for the full payment of any bills incurred as a result of my treatment with the **Center for Orthopaedic Injuries and Disorders** after payment by personal injury protection insurance or other liability insurance. I understand that payment of any balance may be postponed until the time of settlement upon issue of an acceptable **Letter of Protection** by my attorney to the **Center for Orthopaedic Injuries and Disorders**. I also understand that if this **Letter of Protection** is not honored or if I change my attorney that I will be responsible for the balance in full. I do also, hereby, waive all rights to attorney/client privilege and authorize **Theodore P. Vlahos, M.D. and the Center for Orthopaedic Injuries and Disorders** to obtain any and all information from my attorney that they, in their sole discretion, deem necessary.

In the event that surgery is needed, the **Center for Orthopaedic Injuries and Disorders/Dr. Vlahos** may choose to have the hospital or surgery center bill the health insurance, HMO or PPO if available. This does not imply or suggest that they will accept the health insurance, HMO or PPO payments for the surgeon's fee. **I understand and agree to the above.**

______________________________ ____________________

Signature Date

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ASSIGNMENT OF BENEFITS FORM, AUTHORIZATION TO PROVIDE COPY OF UPDATED PERSONAL INJURY PROTECTION PAYOUT SHEET AND TO RESERVE PIP AND/OR MED PAY FOR BILLS AT ISSUE IN THE EVENT OF A LAWSUIT.

The undersigned patient hereby assigns the benefits of insurance and any and all causes of action under the policy of automobile insurance with ____________________________
(name of insurance company)
for an accident which occurred on or about ______________________ to The Center For Orthopaedic Injuries & Disorders for services rendered to the undersigned patient and covered by the Personal Injury Protection (PIP) and/or Med Pay coverage under
____________________ policy with ______________________________ and in
(print patient name) (name of insurance company)
accordance with Florida Statute 627.736. The undersigned further agrees to pay any applicable deductible or co-payment not covered by the PIP insurance coverage.

Additionally, upon forwarding payment for any medical services and/or supplies, I direct my applicable personal injury protection and/or medical payments insurance carrier to provide my medical provider with a copy of an updated PIP payout sheet. I hereby authorize my insurance carrier to set aside a reserve for any disputed medical bills charged by this medical provider, so that if my assignee/medical provider exercises its right to sue my insurance carrier for these bills, the PIP benefits will not be exhausted. This request for a reserve can only be amended by me in writing. In the event I have a wage loss claim I direct my insurer to pay bills due and owing to The Center for Orthopaedic Injuries & Disorders prior to payment of any lost wage claim.

________________________________ ________________________________
Signature of Patient Accepted By

____
Date

Center for Orthopaedic Injuries & Disorders

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Theodore P. Vlahos, M.D.

PATIENT ACKNOWLEDGMENT FORM

By signing this form I acknowledge that I have received a copy of the office's Privacy Notice.

____
Print Name

____
Signature

____
Date

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review does not leave the Clinic's offices. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

Public Health and Safety: We may use or disclose your PHI for public health activities, including but not limited to the reporting of disease, injury, vital events, conducting of public health surveillance, investigation and intervention, child abuse or neglect, and for activities related to quality and safety of FDA-regulated products or activities. We may use or disclose your PHI to prevent or lessen a serious threat to the health or safety of another person or to the public, or for national security and intelligence activities authorized by law.

Workers' Compensation: We may disclose your PHI as authorized by laws relating to Workers' Compensation or similar programs.

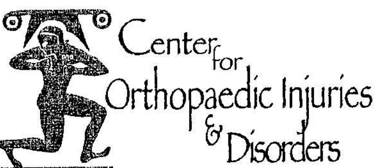
Notification of Family and Friends: With your written permission, we may disclose your PHI to family members, other relatives, or other person(s) you identify, when the PHI is directly relevant to that person's involvement with your care. We may disclose your PHI to others who may be involved in your health care, to notify a family member, or another person responsible for your care of your location, general condition or death. If you are unable to agree or object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment. We also may disclose your PHI to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts. We may disclose such information, as necessary, based on our professional judgment to respond to the emergency circumstances.

Appointment Reminders: We may use or disclose your protected health information, as necessary, to contact you to provide appointment reminders or to reschedule your appointment. We may leave brief messages about your appointments on your answering machine or voice mail.

Alternative Treatment Information: The Clinic is always interested in improving health care and lowering costs for groups of people who have similar health problems, and to help manage and coordinate the care for these groups of people. We may use your PHI to identify groups of people with similar health problems, to provide them with information about treatment alternatives or other health-related benefits and services that we believe may be of interest to them. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer in writing to request that these materials not be sent to you.

ANY OTHER USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION

We will not use or disclose your health information for any other purpose without your written authorization. Once you give written authorization, you may cancel your authorization in writing at any time. If you cancel your authorization we will not disclose protected health information about you after we receive your cancellation, except for disclosures made or processed, before we received your cancellation.



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CENTER FOR ORTHOPAEDIC INJURIES & DISORDERS

Notice of Privacy Practices

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.

CENTER FOR ORTHOPAEDIC INJURIES & DISORDERS is required by federal and Florida law to maintain a record of the care and services you receive at the Clinic. We understand that this information about you and your health is personal, and we are committed to protecting the privacy and security of your health information.

This Notice of Privacy Practices (the "Notice") describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, as well as other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information"(or "PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice applies to all your PHI maintained by the Clinic, whether the PHI is created by your treating Clinic physician, by your referring physician, by a nurse, or by others working at or with the Clinic.

The Clinic is required by law to abide by the terms of this Notice. In this regard, we are required by law to:

- make sure that your PHI is kept private;
- give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- follow the terms of this Notice as currently in effect.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice at any time, and we reserve the right to make the changed Notice effective for all health information that we maintain at the time of the revision. If we revise the terms of this Notice, we will post a revised notice at all Clinic offices. We also will make paper copies of the revised Notice available upon request.

HOW TO CONTACT THE CLINIC

If you would like further information regarding your rights or regarding the uses and disclosures of your health information, you may contact our Privacy Officer at 727-772-0819

THIS NOTICE IS EFFECTIVE AS OF April 14, 2003.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

You have the following rights with respect to your protected health information:

Right to Request Restrictions: You may request that we restrict or limit the protected health information we use or disclose about you for treatment, payment, or health care operations, or you may request a limit on the PHI we disclose to others who are involved in your care (i.e., a non-Clinic physician, a laboratory) or in the payment for your care. We are not required to agree to your request; but if we do, we will honor it. Even if we agree to your request, your restrictions might not be applied in certain situations. For example, in an emergency, we may use or disclose the PHI, without any restriction, to provide emergency treatment to you. To request a restriction or limitation, your request must be made in writing and submitted to the Medical Records Department.

Right to Request Confidential Communications: You have the right to receive communications from us in a confidential manner, and you may request that we communicate with you about your PHI in a certain way

(e.g., only by mail, only on your cell phone) or at a certain location (e.g., only at work, only at home). Your request for confidential communications must be made in writing to the Medical Records Department and must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to Inspect and Copy: Generally, you may review and obtain a copy your PHI in a designated record set. This right is subject to certain specific exceptions. Your request must be made in writing to the Medical Records Department. We may charge a reasonable fee to cover our copying, mailing, and any other supplies associated with your request. We will notify you of the fee and you may choose to withdraw or modify your request at that time, before any costs are incurred. We reserve the right to withhold the requested information until payment of the reasonable fee is received.

Right to Amend: You may ask us to amend your PHI if you believe that any of the information is incorrect or incomplete. You have the right to request an amendment for as long as the PHI is maintained by the Clinic. We may deny your request for certain specific reasons. For example, we may deny your request if you ask us to amend information that: was not created by us; is not part of the PHI maintained by the Clinic; is not the type of PHI that you would be permitted to inspect and copy; if we determine that the information is correct and complete, or if you fail to explain the reason(s) for your request in writing. Your request to amend your PHI must be made in writing to the Medical Records Department and must specify the reason(s) that support your request. If we deny your request, we will provide you with a written explanation for the denial and information regarding appeal rights you may have at that point.

Right to an Accounting of Disclosures: You have the right to request a written list of certain disclosures of your PHI made by the Clinic. We are not required to account for disclosures made for treatment, payment, or healthcare operations (as described on the following page), disclosures that you authorized, and certain other specific disclosure types. Your request must state the time period which the accounting is to cover. This period may not be longer than six (6) years and may not include dates before April 14, 2003. Your request for an accounting of disclosures must be made in writing to the Medical Records Department. The first accounting you request within a twelve (12) month period will be free. For additional accounting requests during that twelve-month period, we may charge a reasonable fee to cover our costs of providing the accounting. We will notify you of the fee and you may choose to withdraw or modify your request at that time, before any costs are incurred. We reserve the right to withhold the requested accounting until payment of the reasonable fee is received.

Right to a Copy of this Notice: You may request a paper copy of this Notice of Privacy Practices at any time.

Complaints: You have the right to complain to us, and to the Secretary of the U.S. Department of Health and Human Services, if you believe that your privacy rights have been violated. If you choose to file a complaint, you will not be retaliated against in any way. You must submit all complaints in writing to:

31581 U.S. 19 North Palm Harbor, Florida 34684

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. Your PHI may be used and disclosed by your physician, by nurses, technicians, or health care team members, by our office staff, and by others outside of our office that are involved in your care and treatment. When required, we will obtain your authorization before disclosing any of your PHI, and we will use reasonable efforts to share only minimally necessary PHI with others.

Treatment: We may use and disclose your PHI to provide, coordinate, and manage your health care and any related services. For example:

- Your protected health information may be provided to a physician to whom you have been referred, to other physicians who may be treating you, or to a hospital that is involved in your care, to ensure that the physician or hospital has the necessary information to diagnose or treat you.
- We may disclose your PHI from time to time to another physician or health care provider (e.g., a specialist, imaging center or laboratory) who, at the request of your attending physician, becomes involved in your care by providing assistance with your health care diagnosis or plan of treatment.
- We may disclose your protected health information to a pharmacy when calling in a prescription.

Payment: Your PHI may be used and disclosed by the business office to process your payment for the health care services provided to you. For example:

- Before you receive scheduled services, we may share information with your health plan in order to verify eligibility, to ask whether coverage is provided by your plan or policy, to obtain required pre-certification, or to obtain prior approval of payment.
- After you receive services, we may share information with your health plan to support our claim for payment , to review services provided to you for medical necessity, and for utilization review activities.

Health care operations: We may use or disclose, as needed, your PHI in order to support the business activities and operations of the Clinic. These activities include, but are not limited to, reviewing the quality of the care you received, quality assessment activities, employee review activities, training of healthcare students, licensing, and marketing activities, compliance with applicable laws, and conducting or arranging for other business activities. For example:

- We review the quality, efficiency and cost of care that we provide to you and our other patients in order to find more efficient and effective ways to provide service, to develop ways to assist our health care providers and staff in deciding what additional services the Clinic should offer, and to evaluate whether new treatments are effective.
- We may share your PHI with third party "business associates" who perform various activities for the Clinic (e.g., accountants, lawyers, transcription, copy, billing, and collection services). Whenever an arrangement between the Clinic and a business associate involves the use or disclosure of your PHI, we will have a written contract with the business associate that contains terms that will protect the privacy of your PHI.

Disclosure to Department of Health and Human Services We may disclose your PHI when required by the U.S. Department of Health and Human Services, the Florida Department of Health or Agency for Health Care Administration, or their agents, as part of an investigation or determination of our compliance with relevant laws.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect: We may disclose your PHI, in accordance with applicable federal, state, and local law, when it concerns abuse, neglect, or violence to you.

Law Enforcement and Legal Proceedings: As required by law, we may disclose your PHI for law enforcement purposes or other specialized government functions. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We also may disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts, as required by law, have been made to tell you about the request or to obtain an order protecting the requested information.

Coroners, Medical Examiners and Funeral Directors: We may disclose your health information to a coroner, medical examiner or a funeral director.

Organ Donation: We may disclose your health information to an organ donation and procurement organization.

Research: Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. We also may disclose your PHI to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, as long as the health information they

Center for Orthopaedic Injuries & Disorders
Theodore P. Vlahos M.D., P.A.
Certified, American Board of Orthopaedic Surgery

Theodore P. Vlahos, M.D.

GENERAL PATIENT/PHYSICIAN AGREEMENT

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

In any effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physicians level. I have read, understand and agree with the above.

Patient/Guardian Initials: _______________

The patient understands that he/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/she is being treated at their 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 trial 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 or 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/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 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. I have read, understand and agree with the above.
Patient/Guardian Initials: _______________

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

In witness whereof, I have set my hand this date _________________.

_________________________ _________________________
Print Patient's Name Patient's Signature

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LETTER OF PROTECTION
DIRECTION TO PAY

PATIENT: ______________________________

DATE OF BIRTH: ______________________________

DATE OF INJURY: ______________________________

IMPORTANT: THIS IS A CONTRACT. IF YOU DON'T UNDERSTAND THIS THEN CONSULT WITH AN ATTORNEY BEFORE SIGNING.

Patient authorizes and directs his/her present and any future attorneys related to the above-referenced date of injury ("Attorneys") to honor this agreement. This agreement is made in favor of the above-referenced Medical Provider and shall be termed a "Letter of Protection." The Letter of Protection shall serve to place a continuing lien on any proceeds I recover in any legal action related to the above-referenced date of injury. The Direction to Pay applies to the Patient's Attorneys.

Background. Medical Provider expects to be paid from any proceeds related to the above-referenced date of injury in exchange for providing medical care/treatment. Medical provider also agrees not to place patient in collections until the resolution of Patient's claims related to the above-referenced date of injury. Patient expects to receive medical care that is reasonable, related to the above-referenced accident and medically necessary. Patient has sustained injuries as a result of injuries related to the above-referenced date of injury and does not have the funds to pay for the medical care which he/she needs. Patient is signing this Letter of Protection in order to receive medical care.

Insurance Benefits: In the event that there are No-Fault Benefits available to Patient besides Bodily Injury and/or Un-Insured Motorist (aka Underinsured Motorist) coverage, then this Letter of Protection can be used to cover any co-payments and/or deductibles.

Protection of Medical Bills. If Patient recovers any money related to the above-referenced date of injury then Patient shall withhold from those funds, sufficient money to pay the outstanding balance of any bill(s) owed to Medical Provider. It is understood that Attorney's fee/costs are first-in-line and that this Letter of Protection does not interfere with Attorney's retainer agreement with Patient. Patient authorizes Medical Provider to provide Attorney with a copy of Patient's medical records, bills, etc. with regard to the above-referenced date of injury.

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Patient's Responsibility for Bills. Patient understands that he/she is directly responsible to Medical Provider for services rendered and that payment is not contingent on any settlement, judgment or verdict. Patient is still responsible for paying Medical Provider's outstanding bills so long as they are reasonable and related to the above-referenced date of injury and medically necessary.

Patient's Responsibility Regarding His/Her Attorney (Present and Future). Patient is responsible for informing each and every attorney retained by him/her of the existence of this agreement. Medical Provider has the right to notify Patient's Attorney(s) about the existence of this Letter of Protection. Upon request, Patient shall provide status updates about any claims related to the above-referenced date of injury as well as the contact information for any new Attorneys. It is also the Patient's responsibility to advise the Medical Provider at least ten days prior to collecting any funds and to request a bill for any and all outstanding charges. Patient understands that if funds related to the above-referenced date of injury are insufficient to cover the medical bill(s), then Medical Provider has the right to collect the remaining balance.

Disputes: If the Patient fails to pay the Medical Provider's full outstanding balance and Medical Provider is the prevailing party in an action to enforce this Letter of Protection, then Medical Provider shall have the right to recover all attorney fees and costs including post-judgment proceedings. Binding arbitration is an option if both parties agree in writing.

Direction to Pay: ATTENTION ATTORNEY: THIS IS A DIRECTION TO PAY ME MEDICAL PROVIDER. Patient directs his/her Attorneys to pay any outstanding medical bills in connection with the above-referenced date of injury. Patient hereby directs Attorneys to provide a status update in writing within fifteen days of receiving a request from Medical Provider.

Effective Date: This agreement becomes effective when the Patient signs the agreement below.

______________________________ ____________________

Patient Signature Date

______________________________ ____________________

Attorney Signature Date

______________________________ ____________________

Theodore P. Vlahos, M.D. Date