HIPAA Release

Highland Center for Orthopaedics

Brian M. Jurbala, M.D.

Board Certified by the American Board of Orthopaedic Surgery

Fellow of the American Academy of Orthopaedic Surgeons

Fellow of the American Orthopaedic Society of Sports Medicine

Member of the Arthroscopy Association of North America

Certificate of Added Qualifications Hand Surgery - American Board of Orthopaedic Surgery

Specializing In:

Arthroscopic Surgery of the Knee, Shoulder, Elbow and Wrist

Joint Replacement and Reconstructive Surgery of the Knee, Shoulder, Elbow, Wrist and Hand

Rotator Cuff Injuries

Hand Surgery and Carpal Tunnel Syndrome

ACL Reconstruction and Revision of ACL Reconstruction

Meniscal Injuries and Cartilage Transplantation of the Knee

Fracture Care

I, _____, direct my health care and medical services from Highland Center for Orthopaedics providers and payers to disclose and release my protected health information described below to:

NAME	RELATIONSHIP	PHONE NUMBER	EMAIL

Health Information to be disclosed upon the request of the person named above --

(Check one):

- O **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)

O **OR**

- O **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - O Mental health records
  - O Communicable diseases (including HIV and AIDS)
  - O Alcohol/drug abuse treatment
  - O Other (please specify): _____
    _____

Form of Disclosure:

- O Hard copy

This authorization shall be effective until (Check one):

- O All past, present, and future periods,
- O Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the individual giving this authorization Date of birth

_____ _____

Signature of the individual giving this authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

Highland Center for Orthopaedics
PATIENT INFORMATION

PLEASE ANSWER ALL QUESTIONS FULLY

PATIENT

NAME (Last, First, MI)	SOCIAL SECURITY	AGE	BIRTH DATE	SEX	HOME PHONE

MAILING ADDRESS	CITY	STATE	ZIP CODE	EMAIL ADDRESS

SECONDARY MAILING ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER	CITY	STATE	ZIP CODE	WORK NUMBER

DRIVER'S LICENSE NUMBER	STATE	NEAREST RELATIVE OR FRIEND'S NAME	PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	SUBSCRIBER'S NAME	RELATIONSHIP	POLICY #	GROUP #

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY NUMBER

EMPLOYER'S NAME	ADDRESS	PHONE NUMBER

SECONDARY INSURANCE COMPANY	SUBSCRIBER'S NAME	RELATIONSHIP	POLICY #	GROUP #

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY NUMBER

EMPLOYER'S NAME	ADDRESS	PHONE NUMBER

RESPONSIBLE PARTY

NAME (Last, First, MI)	SOCIAL SECURITY	AGE	BIRTH DATE	SEX	HOME PHONE

MAILING ADDRESS	CITY	STATE	ZIP CODE	EMAIL ADDRESS

EMPLOYER	CITY	STATE	ZIP CODE	WORK NUMBER

DRIVER'S LICENSE NUMBER	STATE	NEAREST RELATIVE OR FRIEND'S NAME	PHONE NUMBER

PRIMARY PHYSICIAN

NAME	PHONE #

REFERRING PHYSICIAN

NAME	PHONE #

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

INJURY INFORMATION

NATURE OF INJURY/COMPLAINT	DATE OF INJURY/COMPLAINT

IS THE INJURY WORK-RELATED? ☐ YES ☐ NO AUTO INJURY? ☐ YES ☐ NO

WHERE DID THE INJURY OCCUR?

IS THERE AN ATTORNEY INVOLVED? ☐ YES ☐ NO	ATTORNEY NAME	PHONE#

EMERGENCY CONTACT INFO - OTHER THAN SPOUSE - NAME	RELATIONSHIP	PHONE #

PATIENT SIGNATURE	DATE

Medical Questionnaire

Patient Name (PRINT) _____ **DATE**: _____/_____/_____ **Date of birth**: _____/_____/_____

MALE FEMALE **(CIRCLE)** **HEIGHT:** _____' _____" **WEIGHT:** _____ LBS **Dominant Hand:** RIGHT LEFT

Pharmacy: _____ **Street:** _____

City: _____ **State:** _____ **Phone number:** _____

Who requested the visit? _____ MD PA ATTORNEY NONE (SELF) **(CIRCLE ONE)**

***What is the main reason for this visit? (CIRCLE ONE)** PAIN NUMBNESS WEAKNESS SWELLING STIFFNESS

***What body part is involved? (CIRCLE AREA)**

NECK	SHOULDER	ELBOW	HAND	PELVIS	KNEE	FOOT
RADIATES TO: RIGHT LEFT NONE	RIGHT LEFT	RIGHT LEFT	RIGHT LEFT	RIGHT LEFT	RIGHT LEFT	RIGHT LEFT
BACK	**ARM**	**WRIST**	**FINGER**	**TOE**	**ANKLE**	**HIP**
RADIATES TO: RIGHT LEFT NONE	RIGHT LEFT	RIGHT LEFT	T 2 3 4 5 RIGHT LEFT	T 2 3 4 5 RIGHT LEFT	RIGHT LEFT	RIGHT LEFT

***How long ago did it start?** _____DAYS _____WEEKS _____MONTHS _____YEARS

IN THIS BOX, CIRCLE ONE BOX WHICH BEST DESCRIBES HOW THE PROBLEM STARTED AND BRIEF EXPLANATION

- **NO INJURY** _____
- **INJURY** _____
- **INJURY AT WORK** _____
- **WORK RELATED (NO INJURY)** _____
- **AUTO ACCIDENT** _____

DO YOU HAVE A WORKER'S COMP CLAIM? YES NO (CIRCLE ONE)

***On a scale of 1-10 (10 is the worst) how SEVERE is your pain? (CIRCLE)** 1 2 3 4 5 6 7 8 9 10

***What is the quality of pain? (CIRCLE)** SHARP DULL STABBING THROBBING ACHING BURNING

The pain is? (CIRCLE) CONSTANT COMES AND GOES **Does the pain wake you from sleep?** YES NO

What makes your symptoms worse? _____

What makes your symptoms better? _____

What medications are you taking now (or previously) for this issue? _____

_____

Have you had any of these treatments? (CIRCLE) INJECTION BRACE PHYSICAL THERAPY CANE/CRUTCH

Were you seen in the E.R.? (CIRCLE) YES NO **Which E.R.?** _____ **Date?** _____

What tests/scans have you had for this issue? (CIRCLE) X-RAYS MRI CAT scan Bone Scan NERVE TEST (EMG/NCV)

Have you already had surgery for this body area recently or in the past? (Circle, explain if necessary) YES NO

Procedure _____ **Surgeon**_____ **City**_____ **Date** _____

Current work status (CIRCLE) REGULAR LIGHT DUTY NOT WORKING DISABLED RETIRED STUDENT

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: (CIRCLE) DISABILITY WORKMAN'S COMP UNEMPLOYMENT

Name _____ Date_____

REVIEW OF SYSTEMS

M/S Have you had prior problems with this same orthopedic condition in the last year? YES NO

CIRCLE ANY SYMPTOMS YOU'VE HAD IN THESE AREAS						YEAR
GI	HEARTBURN/ULCERS	NAUSEA/VOMITING	BLOOD IN STOOL	HEPATITIS	LIVER DISEASE	
ENDO	THYROID DISEASE	HEAT INTOLERANCE	COLD INTOLERANCE			
CON	WEIGHT LOSS	FREQUENT FEVER	LOSS OF APPETITE			
EYE	BLURRED VISION	DOUBLE VISION	VISION LOSS			
ENT	HEARING LOSS	HOARSENESS	TROUBLE SWALLOWING			
CV	CHEST PAIN	PALPITATIONS				
RS	CHRONIC COUGH	SHORTNESS OF BREATH				
GU	PAINFUL URINATION	BLOOD IN URINE	KIDNEY PROBLEMS			
SK	FREQUENT RASHES	SKIN ULCERS	LUMPS	PSORIASIS		
NEU	HEADACHES	DIZZINESS	SEIZURES			
PSY	DEPRESSION	DRUG ADDICTION	ALCOHOL ADDICTION	SLEEP DISORDER		
HEM	EASY BLEEDING	EASY BRUSING	ANEMIA			

1. ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO If yes, please list and describe reaction

_____

_____

PAST MEDICAL HISTORY

What medications do you take? (LIST DOSAGE) _____

_____

_____

Are you a diabetic? (CIRCLE) YES NO **TREATMENT: (CIRCLE)** INSULIN ORAL MEDS DIET NONE

Are you taking or have you taken blood thinners? YES (list) _____ NO

Past surgeries: _____

Past hospitalizations: _____

Have you had any prior reactions to anesthesia? (CIRCLE) YES NO

Have you ever had: (CIRCLE) HEART ATTACK (YEAR) _____ HIGH BLOOD PRESSURE BLOOD CLOTS (YEAR) _____?

STROKE HEART FAILURE ANKLE SWELLING KIDNEY FAILURE ASTHMA SULFA ALLERGY ASPRIN SENSITIVITY

STOMACH ULCERS BLEEDING ULCERS ISSUES WITH ANTI-INFLAMMATORIES (LIST) _____

CANCER (LOCATION) _____ NONE

FAMILY HISTORY

Have any direct relatives had any of the following disorders? (CIRCLE) **Which Relative(s)?** _____

DIABETES HIGH BLOOD PRESSURE HEART DISEASE RHEUMATOID ARTHRITIS NONE

Do any direct relatives have the same condition you are being seen for today? YES (WHICH ONE) _____ NO

SOCIAL HISTORY

Do you use tobacco? YES (Packs per day_____) NO **Alcohol use?** YES NO **How often?** DAILY WEEKLY

Marital Status: MARRIED SINGLE DIVORCED WIDOWED **How many people live with you?** _____

Occupation: _____ **Employer:** _____

Do you like your job? YES NO **Do you plan on working 6 months from now?** YES NO

PLEASE SIGN:

The information on these two forms is accurate to the best of my knowledge. _____

FOR OFFICE USE ONLY

7

Complete _____ Date ___/___/___ Review #1 by _____ MD Date ___/___/____ Review #2 by _____ MD Date ___/___/___

Highland Center for Orthopaedics

Patient Consent for Use and Disclosure of Protected Health Information

With my consent HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY, may use and disclose protected health information (PHI) about me to carry out treatment and healthcare operations (TPO). Please refer to HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been given a copy of the Notice of Privacy Practices prior to signing this consent.

HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY reserves the right to revise its Notice Of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY. Privacy Officer at 2161 County Road 540 A #286, Lakeland, FL 33813.

With my consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and may call pertaining to my clinical care, including laboratory results among others.

With my consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as the are marked Personal and Confidential.

With my consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may e-mail to my home or the designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and laboratory results. I have the right to request that HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may decline to provide treatment to me.

Please describle below any information you wish to not be released such as date(s) of service, level of detail to be released, orgin of information, etc.

_____

_____

_____

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Highland Center for Orthopaedics
Authorization to Release Information

Surgery

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying is responsible for payment of the account, according to the policy outlined on the previous pages.

Authorization to Release Information and Assignment of Benefits

Consent to Treatment: I the undersigned, am the patient (or the duly authorized representative), and authorize care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician, his/her assistants or designees.

Photographs/Video Tapes: I give consent for any photographs and/or video taping deemed necessary by my surgeon. I understand these photographs and/or video tapes are the property of my surgeon.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance or other health plan to the surgery center.

Release of Information: A photocopy of this assignment is to be considered as valid as an original and revocable by me only in writing. I herby authorize said assignees to release all information to secure payment.

Financial Responsibility: I accept ultimate financial responsibility for accounts with the Highland Center whether paid by insurance or not. Please be advised that the estimate of your charge is based on the procedure(s) and information supplied by your physician's office at the time your procedure is scheduled. During your procedure, additional procedures may be necessary depending on the findings during the procedure. We will bill you or your insurance company for all the procedures and associated costs. You are obligated to pay any amount not covered by your verified insurance plans. This payment may be due prior to the procedure. If any unpaid balances should be sent to collections or an attorney, you will be responsible for all/any collection fees.

Date	Signature	Printed Name

This patient is a minor _____ years/months of age. The patient unable to sign above

_____ Legal Guardian initials

Witness:

Date	Signature	Printed Name

3317 U.S. Hwy. 98 South, Suite 9
Lakeland, Florida 33803
(863) 709-8777

Highland Center for Orthopaedics

22411 Highway 27
Lake Wales, Florida 33859
(863) 676-1571

www.highlandortho.com

Patient Questionnaire

(PLEASE PRINT)

Patient Name:_____ Date of Birth: _____

Patient Signature: _____ Date: _____

Please complete for your chart. Please answer by putting a checkmark in the appropriate box.

RACE

- ❑ American Indian / Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Declined
- ❑ Nat Hawaiian / Pacific Islander
- ❑ Other Race
- ❑ White

RELIGION

- ❑ Buddhist
- ❑ Catholic
- ❑ Hindu
- ❑ Islam
- ❑ Jewish
- ❑ Protestant
- ❑ Other
- ❑ N/A

ETHNICITY

- ❑ Declined
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

PREFERRED COMMUNICATIONS

- ❑ Declined
- ❑ Email
- ❑ Fax
- ❑ Mail
- ❑ Patient Portal
- ❑ Phone
- ❑ Text