



NEW PATIENT PACKET

DATE: _____ PATIENT NAME: _____

Your appointment for evaluation with Dr. Philip J. Orisek is scheduled for:

_____ at _____ a.m. p.m.

Dr. Orisek personally evaluates all new Orthopaedic Spine Patients in our clinic for their initial appointment. He works closely with our Physician’s Assistant, Phil Lanum, P.A., who is also First Assistant Surgeon for most of the surgical procedures. You may be scheduled with our P.A. for any future follow up appointments. There is \$50.00 cancellation fee for failure to keep any scheduled appointment without 24 hour notification.

New Patients must complete all items on the checklist below BEFORE the first appointment. Failure to do so will result in a delay and/or rescheduling of the appointment.

Due to the nature of our practice, we are obligated to prioritize surgical emergencies, thus clinic hours are subject to change accordingly. Please be sure to provide 2 phone numbers and an email address in case we need to notify you of any scheduling issues, including appointment confirmations. If we are not able to reach you, your appointment will be re-scheduled. We will need at least 24 hr in advance that you intend on coming to your appointment. We hope you understand our need to do so as there are many people waiting to see Dr. Orisek.

NEW PATIENT CHECKLIST

ALL ITEMS MUST BE COMPLETE BEFORE FIRST APPOINTMENT

- 2 - New Patient Information
- 3-5 - Complaint Summary
- 6-9 - Medical History
- 10 - Financial Policy
- 11 - ACR
- 12-13 - Notice of privacy
- Imaging Studies (Films, CT Scans, MRIs, etc.)
- ID + Insurance Cards

PLEASE HAND CARRY ANY IMAGING STUDIES TO EVERY APPOINTMENT. PLEASE MAKE ARRANGEMENTS TO OBTAIN THESE ITEMS BEFORE YOUR APPOINTMENT OR YOU WILL BE RESCHEDULED.



PHILIP J. ORISEK, M.D., INC.

RECONSTRUCTIVE ORTHOPAEDIC SPINE SURGERY

2575 East Bidwell Street, Suite 220
Folsom, CA 95630
Phone (916) 817-6390
Fax (916) 817-6385

Kate@orisekspine.com

www.orisekspine.com

NEW PATIENT INFORMATION

PATIENT INFORMATION

Name: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

DOB: _____ SSN: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Relation: _____

Phone: (H) _____ (W) _____ (C) _____

REFERRAL INFORMATION

Referring Physician: _____

Phone: _____ Fax: _____ Email: _____

Primary Care Physician: _____

Phone: _____ Fax: _____ Email: _____

Prior Imaging Studies Completed: MRI CTSCAN X-Ray Other:

FINANCIAL RESPONSIBILITY

Health Insurance Worker's Compensation Self-Pay Medicare Medi-Cal Other

Insurance: _____ ID: _____ Group: _____

Subscriber: _____ DOB: _____

Secondary Insurance: _____ ID: _____ Group: _____

Claim #: _____ DOI: _____ Adjuster: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Employer: _____

Legal Representation: _____

Contact: _____

Phone: _____ Fax: _____ Email: _____



COMPLAINT SUMMARY

Name: _____

Briefly Describe Your Symptoms: _____

Describe Onset of Symptoms : - For example : sudden injury or spontaneos pain

Have you had any Bowel or Bladder Incontinence? _____

Have you had any Loss of Consciousness? _____

Does your injury involve any of the following: * Describe in detail below.

- | | | | |
|---------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> Scarring | <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Severe Brain Injury | <input type="checkbox"/> Animal Bites |
| <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Loss of a Sense | <input type="checkbox"/> Heart Attack | |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Dental Injury | <input type="checkbox"/> Burns | |

Description: _____

Do you have any health issues or preexisting conditions? (Previous injuries, illnesses, diseases, accidents, surgeries, scoliosis, etc.)

Describe in full detail the cause and after effects of the injury:

Has this affected your activities of daily living? If so, how much and in what ways?

How is your quality of life at this time? _____



COMPLAINT SUMMARY

Summary of Treatment in chronological order, including length of treatment:

Were you receiving active treatment at time of current incident/condition? YES NO

How long since last treatment? _____

List all medications or devices used:* Include TENS units, over the counter medications, herbal supplements, and all pain medications

Tens units w/relief

Tens units w/no relief

Check any symptoms noted after the accident: * Describe in detail below.

- | | | |
|--|--|---|
| <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Headache | <input type="checkbox"/> Neurosis |
| <input type="checkbox"/> Radiating Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Restricted Movement | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bruising/Lacerations | <input type="checkbox"/> Vision Disturbances | <input type="checkbox"/> Bowel/Bladder Incontinence |
| <input type="checkbox"/> Loss of Consciousness | | |

Description: _____

When did you last seek medical treatment? _____

If there was a delay in seeking treatment, please indicate why: _____

Where were you treated for your condition? * Describe treatment and length of hospitalization.

- | | | |
|---|---|--|
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Family Doctor |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other |

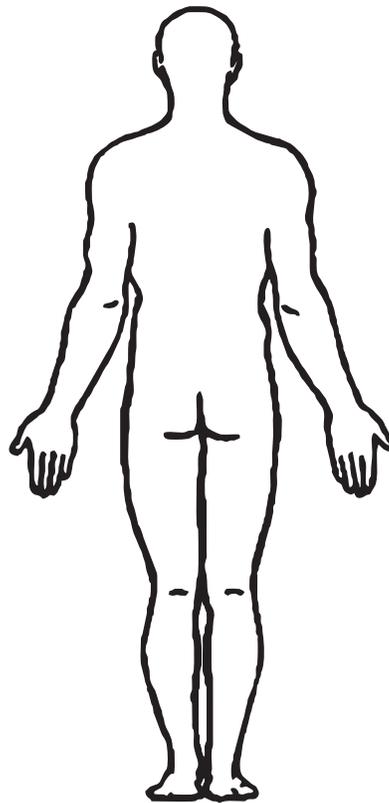
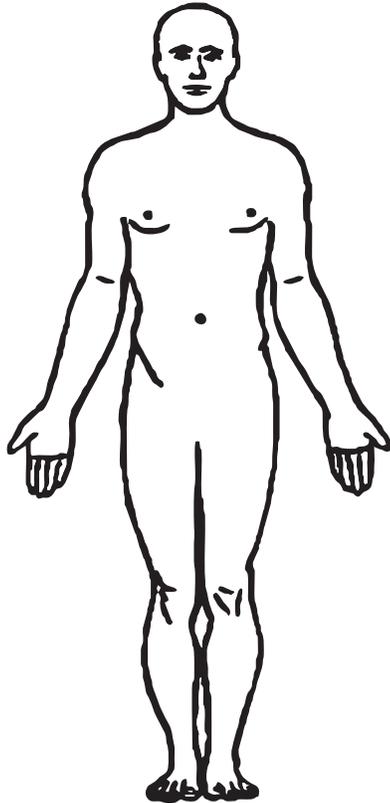
Description: _____



COMPLAINT SUMMARY

MARK THESE DRAWINGS ACCORDING TO WHERE YOU FEEL PAIN

///// STABBING XXXXX BURNING 00000 PINS & NEEDLES ===== NUMBNESS +++++ ACHING



Pain Scale

How much of your pain is in your neck/back and how much is in your arm/leg?

_____ %neck/back + _____ % arm/leg = 100%

PAIN LEVEL:

0 1 2 3 4 5 6 7 8 9 10

(Check the worst & best it's been and circle your current pain level)

- 0 No Pain
- 1 Mild Pain; you are aware of it, but it doesn't bother you
- 2 Moderate pain that you can tolerate without medication
- 3 Moderate pain that requires medication to tolerate
- 4-5 More severe pain; you begin to feel antisocial
- 6 Severe pain
- 7-9 Intensely severe pain
- 10 Most severe pain; Emergency Room Care

MEDICAL HISTORY

PHYSICAL SYMPTOMS

Where is your pain?	How long has it been there?
<input type="checkbox"/> Head	_____
<input type="checkbox"/> Neck	_____
<input type="checkbox"/> Shoulder (L) (R)	_____
<input type="checkbox"/> Arm (L) (R)	_____
<input type="checkbox"/> Hand (L) (R)	_____
<input type="checkbox"/> Mid Back	_____
<input type="checkbox"/> Low Back	_____
<input type="checkbox"/> Buttock or Hip (L)(R)	_____
<input type="checkbox"/> Leg (L) (R)	_____
<input type="checkbox"/> Other	_____

How often are you having pain right now?

Rarely if ever

Occasional (1-2 episodes per year)

Recurrent (2-3 days every few months)

Frequent (>3 days per month)

Very Frequent

Every Day

What time of day is your pain usually worse?

Morning Same all day

Mid-day At night in bed

Evening

Since the onset of pain, have you noticed any of the following symptoms?

- Numbness/weakness in arm (L), (R)
- Numbness/weakness in hand (L), (R)
- Numbness/weakness in legs (L), (R)
- Numbness/weakness in feet (L), (R)
- Clumsiness of hands (L), (R)
- Balance problems
- Bladder problems
- Bowel problems
- Pain that wakes you from sleep

What makes your pain worse?

- Lying down Looking up/down
- Sitting Looking (L) (R)
- Standing Bending forward
- Walking Bending back
- Lifting Sneeze/cough
- Sleeping Twisting

When having pain is it generally...

- Mild discomfort or less
- Dull pain, worse at times
- Hard aching pain, frequently worse
- Severe pain, sharp/shooting at times
- Very severe pain, sharp, shooting, disabling
- Extremely severe and disabling

What makes your pain better?

- Lying down Looking up/down
- Sitting Looking (L) (R)
- Standing Bending forward
- Walking Bending back
- Lifting Sneeze/cough
- Sleeping Twisting

Describe the course of your condition as...

- Rapidly worse Rapidly better
- Slowly worse Slowly better
- Unchanged

What studies have been done on your spine?

- None X-ray
- CT scan Myelogram
- MRI scan Bone scan



MEDICAL HISTORY, CONTINUED

What treatment have you received?

- None
- Medication
- Manipulation
- Traction
- Physical Therapy
- Spinal Block
- Hospitalized
- Other:

Past Medical/Surgical History

Do you have any medical problem for which you regularly see a doctor?

- No
- Yes:

Please rate your general health

- Excellent
- Good
- Fair
- Poor

Have you had prior surgeries?

- No
- Yes:

Please list your medications and herbs:

Do you have any allergies to medication?

- No
- Yes - list drug(s) and reaction(s):

Are you allergic to latex?

- No
- Yes

Are there any medical problems that tend to run in your family?

- No
- Yes - list family member and condition:

Social History

What level of education have you completed?

- Grade school
- College
- High school
- Graduate school

Are you presently employed?

- No - How long since you were? _____
- Yes - Where and for how long? _____

What is your occupation?

Present occupation _____

Prior occupation _____

Activities at home or work mostly involve:

- Manual labor, heavy lifting
- Manual labor, less strenuous
- Sitting most of the day
- Walking or standing most of the day
- House work and child care

How is pain limiting your job/home activities?

- Not limited in anyway
- Not limited much due to pain
- Able to work around the pain
- Must stop and limit activities
- Unable to work for days at a time
- Unable to work at all due to pain

How is pain limiting your social/recreational activities?

- Not limited in anyway
- Not limited much due to pain
- Able to do most things with the pain
- Modify activities to control the pain
- Greatly limit activities to control the pain
- Unable to participate in any activities

Do you exercise on a regular basis?

- No
- Yes - doing what, how many days/week?

Do you smoke or chew tobacco?

- No
- Yes - how much?

Do you drink alcohol (beer, wine, liquor)?

- No
- Yes - how often/much?

Have any of the following reasons caused you to be emotionally upset recently?

- Not upset
- Marital
- Social
- Work
- Legal
- Financial



MEDICAL HISTORY, CONTINUED

Review of Symptoms

Please indicate if you have:

- Fever or chills
- Weight loss
- Sinus problem
- Sore throat
- Productive cough
- Lung disease
- Stomach problems
- Bowel disease
- Bladder problems
- Memory loss
- Seizures
- Dizziness
- Depression
- Mental illness
- Joint pain
- Muscle weakness
- Hepatitis
- HIV
- Visual problems
- Hearing loss
- Dental problems
- Heart disease
- High blood pressure
- Shortness of breath
- Ankle/leg swelling
- Chest pain
- Kidney disease
- Urination problems
- Diabetes
- Thyroid disease
- Allergies
- Rash
- Bleeding disorder
- Anemia
- Cancer

Outcome Assessment

Please answer the following by checking only ONE box for each question.

Please rate your average pain from 0 - 10.

At present, are you working?

(Housewives and retired persons relate activity to previous abilities)

- Full time at usual job
- Full time at a lighter job
- Part time
- Not working

At present, can you undertake household chores or odd jobs?

- Normally
- As much as usual but slow
- A few, not as many as usual
- Not working

At present, can you undertake sporting or social pursuits?

- As much as usual
- Some, much less than usual
- Almost as much as usual
- Not at all

How often have you seen a doctor or had treatment (e.g., physical therapy) for your pain?

- Never
- About once a month
- Rarely
- More than once a month

How does the pain affect the following activities?

	Severely Impossible	Moderately Difficult	Mildly Not Much	Not At All
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



MEDICAL HISTORY, CONTINUED

Self Assessment

	Never	A little	A lot	Always
Feeling hot all over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating all over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurring of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling faint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Churning in the stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth becoming dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck muscles aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs feeling weak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscles twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tense forehead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel down-hearted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel best in the AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have crying spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have lost my appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I still enjoy sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My heart beats fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm tired for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can't do things I used to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopeful about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decisions come easy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I'm useful and needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life is pretty full	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy things I used to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It would be best if I died	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think I have lost weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often do you take pain killers?

- Never Occasionally
 Almost every day Several times each day

Do you rest during the day because of pain?

- No A little
 Half the day Over half the day

Pain Scale

How much of your pain is in your neck/back and how much is in your arm/leg?

_____ %neck/back + _____ % arm/leg = 100%

PAIN LEVEL:

0 1 2 3 4 5 6 7 8 9 10

(Check the worst & best it's been and circle your current pain level)

- 0 No Pain
- 1 Mild Pain; you are aware of it, but it doesn't bother you
- 2 Moderate pain that you can tolerate without medication
- 3 Moderate pain that requires medication to tolerate
- 4-5 More severe pain; you begin to feel antisocial
- 6 Severe pain
- 7-9 Intensely severe pain
- 10 Most severe pain; Emergency Room Care

FINANCIAL POLICY

Prior to the doctor/patient relationship being established, it is very important that you understand and consent to Philip J. Orisek, M.D., Inc.'s financial policy as set forth below:

You, as the patient, are responsible for the entire amount of the bill for any services rendered to you by Philip J. Orisek, M.D., Inc. (PJOMD, Inc.) PJOMD, Inc. is NOT contracted with any insurance providers¹. On occasion, certain insurance companies will agree to pay for a portion of PJOMD, Inc.'s services as an out of network provider, and on certain occasions, PJOMD, Inc. will work with those carriers to process those benefits to you. PJOMD, Inc. will only agree to process out of network payments from your health insurance carrier, if you agree that any such payments will be made directly from the carrier to PJOMD, Inc. Additionally, to the extent that any such benefits fail to satisfy the balance owing on your account, you will remain financially responsible for those unpaid sums.

All accounts shall be resolved within thirty (30) days from the date they are invoiced unless alternative arrangements for payment have been made².

A 10% discount will be offered if payment is received in full at the time of service. Cash and credit cards are accepted.

If you are unable to pay your balance in full within thirty (30) days of being invoiced, our billing coordinator will assist you in arranging a payment schedule or other acceptable arrangements.

All accounts not paid within forty-five (45) days of billing, in the absence of an alternative agreement, may be referred to an outside agency for further action, reported to the local credit reporting bureau, or the subject of other collection proceedings.

By my signature below, I acknowledge that I am responsible for paying for all medical services rendered to me by PJOMD, Inc. pursuant to the terms stated above.

Patient's Printed Name

Patient's Signature

¹Medicare recipients and Worker's Compensation patients are addressed on a case by case basis.

²Note, if you have executed a lien agreement with PJOMD, Inc., the terms of that agreement will determine your payment obligations.

CONSENTS & RELEASE

CANCELLATION POLICY

If you are running late for your appointment, please call (916) 817-6390 to let us know. We will see if you can still be seen within 15 minutes of your appointment time and we will accommodate you based on the doctor's schedule. I understand that I will be responsible for a \$50.00 cancellation fee for failure to keep any scheduled appointment without 24 hour notification.

INITIAL

RELEASE OF MEDICAL RECORDS

I consent for Philip J. Orisek, MD, Inc. to release or obtain my medical records/information to/from any insurance company, attorney, insurance adjuster, referring physician, primary physician, internist, employer or other entity as may be appropriate for treatment, payment or health care operations as specifically set forth in the Notice of Privacy Practice that has been provided to me.

INITIAL

CONSENT TO TREAT

I consent to all necessary examination procedures and/or treatments prescribed by my physician, physician assistant or designees as is necessary in his/her judgment.

INITIAL

NARCOTIC PAIN MEDICATION AGREEMENT

I have/have not been diagnosed with or treated for substance dependence or abuse.
 I have/have not been arrested for or involved in the sale, illegal possession, diversion or transport of controlled substances.
 I agree to obtain all my prescriptions for pain medication only from Dr. Orisek, unless instructed otherwise by Dr. Orisek.
 I agree to supply the name, address and phone number of the pharmacy filling my prescriptions for pain medication to Dr. Orisek.
 I agree that Dr. Orisek may send a copy of this agreement to my pharmacy, my referring physician and all other physicians involved in my care.
 I agree to take the medication only and exactly as directed by Dr. Orisek.
 I understand that each prescription is written for a specific amount of medication and is designed to last a certain amount of time. I understand that there will be no allowance for lost or stolen prescriptions or pills. I understand that no prescriptions for pain medications will be given over the phone.
 I agree that I will not obtain pain medication from any other physician or emergency room without Dr. Orisek's knowledge.
 I agree to keep my scheduled appointments with Dr. Orisek.
 I agree to follow the advice of Dr. Orisek regarding stopping use of the controlled substance, should he feel it is advisable.
 I attest, to my knowledge, that I am not pregnant, and that I will notify Dr. Orisek if I do become pregnant or are planning to do so.
 I understand that Dr. Orisek will stop the pain medication if any of the following occur: I develop rapid tolerance to or loss of effectiveness of the pain medication; I develop side effects from the pain medication; my functional activity level decreases.
 I understand that my pain medication by Dr. Orisek will be stopped if I am noncompliant with any of the terms of this agreement.
 I have read and understand this agreement, and I have had all of my questions answered to my satisfaction.

INITIAL

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer.

How This Medical Practice May Use or Disclose Your Health Information This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearing-houses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

NOTICE OF PRIVACY PRACTICES, CONTINUED

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.

Worker’s compensation. We may disclose your health information as necessary to comply with worker’s compensation laws. For example, to the extent your care is covered by workers’ compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers’ compensation insurer.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child’s records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice’s denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and disclosure of protected health information is regulated by the federal law known as The Health and Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, providers of health care are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I _____ (print name of patient or personal representative), acknowledge that Philip J. Orisek, M.D., Inc. has provided a written copy of their Notice of Privacy Practices to (check one) myself or specify _____

If you are signing as a personal representative, documentation of your legal right to do so must be provided.

Patient Name
x

Signature of Patient/Responsible Party

Date of Birth

Date