ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.

One Orthopaedic Place • St. Augustine, FL 32086
3055 CR 210 W, Suite #110 • St. Johns, FL 32259
Ph (904) 825-0540 • Fax (904) 825-2490
www.oastaug.com

Nursing Home and Assisted Living Patient Checklist

In order to perform the optimum care and service to your residents we require the following information be provided **prior** to receiving an evaluation with our medical staff. Please complete this form and fax to appropriate number below. After we receive the completed form our staff will call to schedule the patient's appointment.

1. Name of your facility: _____
2. Phone: #_____
3. Insurance information & copies of all insurance cards
4. Information sheet containing diagnosis and referring physician request for a consult, when appropriate
5. List of all current medications\drug allergies
6. Please complete form below and return with paperwork

MUST BRING COPIES OF RECENT X-RAYS - 2 AP LATERAL OF THE AFFECTED SITE(S) AND LABS

Location being seen at: Saint Augustine____☐____ CR 210____☐____
St Augustine fax # 904.209.1034 **CR 210 fax # 904.287.7876**
Reason for Visit to our Clinic_____
Is this Hospital Follow Up? Yes____☐____ No____☐____ If yes, date_____
What doctor do they need an appointment with_____
Will patient be arriving by stretcher? Yes____☐____ No____☐____

Name of Patient: _____
Address _____
Phone # _____ SS# _____ DOB _____
Emergency Contact _____ Relationship_____
Primary Ins. _____ Policy # _____
Policy Holders Name _____ Relationship _____
Secondary Ins. _____ Policy # _____
Policy Holders Name _____ Relationship_____
POWER OF ATTORNEY PAPERWORK MUST BE INCLUDED, IF APPLICABLE

Patient Signature _____ Date _____

Power of Attorney Signature _____ Date _____
Revised 9/14

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Welcome to our office. We are committed to providing you with the most comprehensive care possible. Please assist us in doing so by providing the following information, as well as your ***driver's license and insurance card(s).***

Today's Date: _____

Last Name: _____ **First Name:** _____ **Middle:** _____

Soc Sec Number: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

Address: _____ **Apt./Lot #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone (H): (_____) _____ **(W):** (_____) _____ **(Cell):** (_____) _____

(Please complete the secondary address if you are not a full-time resident of this area)

Secondary Address: **Apt./Lot #:** **Phone: ( )**

City: **State:** **Zip Code:**

E-mail Address: _____ **(If you would like to receive e-mails from our office)**

Employer (Parent's Employer if the patient is a minor/child): _____

Employer Phone: (_____) _____ **Position:** _____

Emergency Contact: _____ **Phone:** (_____) _____ **Relationship:** _____

How did you hear about us? _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policyholder Name: _____ **Policyholder Name:** _____

Policyholder Date of Birth: _____ / _____ / _____ **Policyholder Date of Birth:** _____ / _____ / _____

Primary Care Physician: _____ **Phone:** (_____) _____

Referred by (Physician): _____

Have you had an X-ray/MRI/CT Study done for this problem? Y / N

Please indicate what study you have had for this problem:

X-Ray ☐ **Yes** ☐ **No** **Date Done:** _____ **What Facility?** _____

MRI ☐ **Yes** ☐ **No** **Date Done:** _____ **What Facility?** _____

CT ☐ **Yes** ☐ **No** **Date Done:** _____ **What Facility?** _____

INDIVIDUALS AUTHORIZED TO RECEIVE MY MEDICAL INFORMATION

I hereby authorize the designated parties below to request and receive any Protected Health Information (PHI) regarding my treatment, payment or administrative information related to treatment or payment. I understand that the identity of designated parties must be verified before the release of any information by providing proof of identification (i.e. Photo ID). **If you would like your health information/PHI to be accessible to any immediate family members (i.e. spouse, child, parent), it is necessary to include them on the list below.**

Individuals Authorized to have access to my health information/PHI:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____
Print Patient Name

_____ _____
Patient Signature/or Patient Guardian Signature Date

Notice of Privacy Practices are posted in the lobby.

Medical Questionnaire

Office Use Only:

Referred By: _____

Appointment Date _____ Chart # _____ Provider _____

Patient Name (Print) _____ DOB _____

Age ____ ☐F ☐M Dominant hand ☐R ☐L Did you bring x-rays? ☐Y ☐N

Who requested that you visit this office? (Name) _____ ☐MD ☐PA ☐Attorney ☐None (Self-Referral)

PROBLEM

What is the main reason for this visit? _____

How long ago did it start? ☐ Days ☐ Weeks ☐ Months ☐ Years. Have you had a problem like this before? ☐Y ☐N

What body part is involved? Please mark in table below. **If more than one, see receptionist.**

Neck ☐	and **radiates** to	☐ R arm ☐ L arm ☐ Neither	Shoulder	☐R ☐L	Elbow	☐R ☐L	Hand	☐R ☐L	Pelvis	☐R ☐L	Knee	☐R ☐L	Foot	☐R ☐L
Back ☐	and **radiates** to	☐ R leg ☐ L leg ☐ Neither	Arm	☐R ☐L	Wrist	☐R ☐L	Finger T 2 3 4 5	☐R ☐L	Hip	☐R ☐L	Ankle	☐R ☐L	Toe B 2 3 4 5	☐R ☐L

Is this problem the result of an injury: Y☐ N☐

If no, was it a gradual onset ☐ or sudden onset ☐

If yes, you MUST complete below:

Where did injury occur _____

Date the injury occurred _____

How did the injury occur _____

_____

Work related: Y☐ N☐

Auto related: Y☐ N☐

Driver☐ Passenger☐ Pedestrian☐

Type of vehicle _____

What did you hit/hit you _____

PAIN

On a scale of 0-10 (10 is the worst) how severe is your pain (write) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is ☐ Constant ☐ Comes and goes (Intermittent). **Does your pain wake you from sleep?** ☐ Yes ☐ No

Do you have? ☐ Swelling ☐ Bruise ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

What makes your symptoms **worse**? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed

☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

Which make your symptoms **better**? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other _____

TREATMENT

What medications have you taken for this current problem? _____

Are you in pain management? Y☐ N☐ Pain management physician's name _____

Have you had any of these treatments? Injection ☐Y ☐N Brace ☐Y ☐N Physical Therapy ☐Y ☐N Cane/Crutches ☐Y ☐N

Were you seen in the E.R. for this problem? ☐Y ☐N Which E.R. _____ Date _____

Are you here today as a result of the E.R. visit? ☐Y ☐N. Who saw you in the E.R. (name) _____ ☐MD ☐PA

What tests/scans have you had for this problem? X-Rays ☐ MRI ☐ CAT scan ☐ EMG/NCS ☐

Where were these tests done? _____

Have you already had surgery for a problem in this same area either recently or in the past? ☐Y ☐N Please list below.

Procedure # 1 _____ Surgeon _____ City _____ date _____

Procedure # 2 _____ Surgeon _____ City _____ date _____

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

Are you currently receiving or plan to apply for: Disability ☐Y ☐N Workers' Comp. ☐Y ☐N Unemployment ☐Y ☐N

NAME: **MRN:** **Appointment Date**

★ **REVIEW OF SYSTEMS:**

	CHECK ANY CONDITION BELOW THAT YOU HAVE						OR CHECK NONE	Describe
MS	Joint Pain ☐		Joint Stiffness ☐				☐	
GI	Heartburn ☐	Ulcers ☐	Nausea ☐	Vomiting ☐	Blood in stool ☐		☐	
ENDO	Frequent Thirst ☐		Frequent Urination ☐		Always Hot or Cold ☐		☐	
CONST	Weight Loss ☐		Frequent Fever ☐		Loss of appetite ☐		☐	
EYE	Blurred Vision ☐		Double Vision ☐		Vision loss ☐		☐	
ENT	Hearing Loss ☐		Hoarseness ☐		Trouble swallowing ☐		☐	
C-VASC	Chest Pain ☐		Palpitations ☐				☐	
RESP	Chronic Cough ☐		Shortness of Breath ☐		COPD Asthma ☐		☐	
GU	Painful Urination ☐		Blood in Urine ☐		Kidney Problems ☐		☐	
SKIN	Frequent Rashes ☐		Skin Ulcers ☐		Psoriasis ☐		☐	
NEURO	Headaches ☐		Dizziness ☐		Seizures ☐		☐	
PSYCH	Drug / Alcohol Problem ☐		Depression ☐		Sleep Disorder ☐		☐	
HEME	Easy bleeding ☐		HIV / AIDS ☐		Hemophilia ☐		☐	

Are you Diabetic? ☐ **Y** ☐ **N** **TREATMENT:** ☐ **Insulin** ☐ **Oral Meds** ☐ **Diet** ☐ **None**

HAVE YOU EVER HAD? : Check any conditions below: ☐ **I do not have any of the conditions listed below**

Back pain ☐	Stomach ulcers ☐	Liver disease ☐	Stroke ☐
Fracture which bone? ☐	Bleeding ulcers ☐	Heart attack ☐	Cancer site _____
Osteoporosis ☐	Kidney failure ☐	High blood pressure ☐	Rheumatoid arthritis ☐
Gout ☐	Hepatitis ☐	Heart failure ☐	Lupus ☐

Blood Clots that you had to take blood thinners to treat? ☐ Y ☐ N When?

Allergy: Do you have ALLERGIES to any medications? ☐ **Y** ☐ **N** **If yes, please list all and reaction**

Name _____ reaction _____

Name _____ reaction _____

Name _____ reaction _____

What medications do you currently take? None ☐ **please list all below**

Medication _____ Dose _____ / Medication _____ Dose _____

Medication _____ Dose _____ / Medication _____ Dose _____

Medication _____ Dose _____ / Medication _____ Dose _____

PAST SURGICAL HISTORY:

What operations have you had? When? ☐ **None** _____

_____

Have you ever had a reaction to anesthesia? ☐ Y ☐ N

PAST HOSPITALIZATIONS (Not for surgery) ☐ **None** _____

Family History: Is your father still living? ☐ Y ☐ N Is your mother still living? ☐ Y ☐ N

Has any direct relative had any of the following disorders? If so, which relative? _____

Hemophilia ☐ High Blood Pressure ☐ Diabetes ☐ Rheumatoid Arthritis ☐

Does any direct relative have the same condition you are being seen for today? ☐ Y ☐ N Relationship _____

Social History: Alcohol use: None ☐ Social ☐ Daily ☐ Frequently ☐ / Drug Use: None ☐ Social ☐ Daily ☐ Frequently ☐

Do you currently smoke? ☐ Y ☐ N packs per day _____ / Have you in the past? ☐ Y ☐ N Do you chew tobacco? ☐ Y ☐ N

Occupation: _____ Martial Status: M S D W

PLEASE SIGN: The information on these two forms are accurate to the best of my knowledge.

Signature _____ **Date** _____

For Office Use Only

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

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PATIENT FINANCIAL AGREEMENT

Completion of Forms

Charges will be incurred for completion of special forms and reports, such as life insurance, disability, and so forth. Payment in full will be collected when the form is received. Please allow five business days for completion.

Assignment of Benefits

My signature, or legal guardian's, confirms that I have received Orthopaedic Associates' (OASA) Financial Policies pamphlet. It also permits OASA to bill and accept payment from my insurance plan, Attorney, or other agency paying my claims for medical services and items received by me. The remaining unpaid portion of my claims is my financial responsibility. I will pay co-payments at time of service per my insurance contract. Please refer to the OASA "Financial Policies" pamphlet for detailed information on all Financial Policies, as well as, payment plans and Care Credit.

Patient financial responsibility

The undersigned understands and agrees that he or she will be financially responsible to pay for any balance not covered by his or her insurance company. This is to include Deductibles, Co-pays and Co-insurance.

The undersigned, if uninsured, agrees to pay a **DEPOSIT** prior to the visit and be financially responsible for any remaining balance resulting from any and all visits.

The undersigned also agrees to be responsible for any costs incurred should the balance be placed with a third party for collections.

Consent for care and treatment

I hereby give consent for medical care and treatment, along with braces, splints, and other items related to my care, as provided by Orthopaedic Associates.

Date _____

Patient _____ Parent/Guardian _____

Print Name _____ Print Name _____

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Name:_____**Account #:**_____**Date:**_____

Preferred Language:
☐ English ☐ Spanish ☐ Other

Race:
☐ American Indian ☐ Asian ☐ Black / African American ☐ White
☐ Alaskan Native ☐ Pacific Islander ☐ decline

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ decline

Pharmacy Preference:
Name_____
Location_____
Phone_____

How would you like to be contacted?
☐ Mail ☐ Phone ☐ E-mail

Request access to your records via our patient portal
Email:_____

*EMAIL ADDRESS REQUIRED for portal access

Smoking Status - for patients 13 years and up
☐ every day ☐ some days ☐ former smoker ☐ never smoked

ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.
NOTICE OF PRIVACY PRACTICES

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

At Orthopaedic Associates of St. Augustine, P.A. ("OASA"), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule effective March 26, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit OASA; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

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

Your Health Information Rights

Although your health record is the physical property of OASA, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. OASA maintains an electronic medical record ("EMR"). You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. OASA may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. OASA is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for OASA; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by OASA, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. Since we maintain your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but OASA may charge you for additional lists within the same 12-month period. OASA will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases OASA is not required to agree to these additional restrictions, but if OASA does, OASA will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). OASA must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or a machine readable electronic format.

Our Responsibilities

OASA is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the OASA Privacy Officer at:

Orthopaedic Associates of St. Augustine, P.A.
1 Orthopaedic Place
St. Augustine, Florida 32086
Telephone: (904) 825-0540
WWW.OASTAUG.COM

If you believe your privacy rights have been violated, you can file a written complaint with OASA's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, OASA operates an EMR. This is an electronic system that keeps health information about you. OASA may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. OASA may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

OASA may use a prescription hub which provides electronic access to your medication history. This will assist OASA health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by encrypted e-mail, in reference to any items that assist OASA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist OASA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. OASA may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your health information to a coroner or medical

examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

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

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at OASA, to a business associate or a foundation related to OASA so that they may contact you to raise money for OASA. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: OASA may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

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

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

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

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your health information if we are required by law to do so.

Acknowledgment of Receipt of Notice

I acknowledge that I have had the opportunity to review a copy of OASA's Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify OASA, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand OASA has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at **WWW.OASTAUG.COM**. *OASA will provide me with a copy of its most recent Notice upon my request.*

Please sign and return a copy of this Notice to OASA.

Patient Name: _____
DOB: _____
Patient Signature: _____

Name(s) of others authorized to discuss or request medical information:

_____
_____
_____
_____

Revised September 23, 2013.