RESURGENS PC
ORTHOPAEDICS

DATE_____

INITIAL PATIENT ASSESSMENT AND HISTORY

Thank you for choosing us to assist in your medical care. Please fill out this form completely to assist us with your visit.

_____
First Name MI Last Name

Age: _____ Sex: Male / Female

Marital Status: S / M / D / W

Height: _____ Weight: _____
Handedness: Left / Right

Are you currently working? _____Yes ____ No
_____ Retired _____ Medically Disabled

Is your pain related to your job? _____
Occupation: _____

Is your pain related to an auto accident?
_____Yes _____ No

Is there litigation pending? _____Yes _____ No

Have you been treated by our physicians in the past?
_____Yes _____ No
If Yes, which physician?_____

History of Symptoms

1. Chief Complaint (please explain why you are here today) _____
   _____
   _____
   Left_____ Right_____
2. When did your symptoms begin? _____
3. What makes your pain better? _____
4. What makes your pain worse?
   ___ lying down ___ sitting ___ walking ___ bending
   Other: _____
5. Do you wake up at night because of your pain?
   ____ Yes ____ No

   Please rate your pain on a scale of 1 to 10

   _____
   I I I
   1 5 10

Medical History

Please list all previous surgeries and dates:
_____
_____
_____
_____
_____

Medications you are currently taking:
_____
_____
_____
_____
_____

Do you or have you used herbal supplements?
Yes / No
If yes, Type: _____
_____

Do you or have you used recreational drugs?
Yes / No
If yes, Type: _____

Allergies you have to medications, food, or environment and the reactions:
_____
_____
_____
_____

Do you smoke? ____ Yes ____ No
Amount: _____ per day/ week

Have you ever smoked? ____ Yes ____ No
Amount: _____ per day/ week

Do you drink alcohol? ____ Yes ____ No
Amount: _____ per day/ week

Review of Symptoms

Do you have a history of any of the following?

Abnormal Bleeding	___ Yes	___ No
Chest Pain	___ Yes	___ No
Cold Hands/ Feet	___ Yes	___ No
Fever/ Chills	___ Yes	___ No
Numbness Hands/ Feet	___ Yes	___ No
Shortness of Breath	___ Yes	___ No
Sleep Disturbance	___ Yes	___ No
Stomach Pain	___ Yes	___ No
Weight Loss	___ Yes	___ No
Muscle Weakness	___ Yes	___ No
Skin rash	___ Yes	___ No
Visual Disturbances	___ Yes	___ No

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Past Medical History

Do you or have you had any of the following medical illnesses? If you answer yes to any of the following questions, please give a short explanation of treatment

AIDS/ HIV	___ Yes	___ No	_____
Arthritis	___ Yes	___ No	_____
Asthma	___ Yes	___ No	_____
Bleeding Disorders	___ Yes	___ No	_____
Cancer	___ Yes	___ No	_____
Diabetes	___ Yes	___ No	_____
Emphysema	___ Yes	___ No	_____
Epilepsy	___ Yes	___ No	_____
Fibromyalgia	___ Yes	___ No	_____
Heart Problems	___ Yes	___ No	_____
Hepatitis	___ Yes	___ No	_____
High Blood Pressure	___ Yes	___ No	_____
Migraines/ Headaches	___ Yes	___ No	_____
Muscle Diseases	___ Yes	___ No	_____
Nerve Disorders	___ Yes	___ No	_____
Osteoporosis	___ Yes	___ No	_____
Psychiatric Disorders	___ Yes	___ No	_____
Stomach Disorders	___ Yes	___ No	_____
Thyroid Disorders	___ Yes	___ No	_____
Other Disorders	___ Yes	___ No	_____

Family History

	Living	Deceased	Age	Cancer	Heart Problems	Diabetes	Other
Father							
Mother							
Sister(s)							
Brother(s)							

Thank you for taking the time to complete this Health History and Medical Assessment.

Patient Signature_____

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Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Summary Privacy Notice for **Resurgens Orthopaedics.**

Privacy Notice Revision Date: April 14, 2003

Patient or Personal Representative's Name Printed _____ Patient or Personal Representative's Signature _____ Patient's Date of Birth _____

Personal Representative's Relation to Patient _____ Date _____

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Summary Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Summary Privacy Notice. However, acknowledgement has not been obtained because:

- ❑ Patient refused to sign the Summary Privacy Notice Acknowledgement.
- ❑ Patient was unable because: _____
- ❑ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- ❑ Other reason, describe below: _____

Employee's Name Printed _____ Employee's Signature _____ Date _____

Authorization to Release Protected Health Information

I, _____, hereby authorize Resurgens Orthopaedics to release my protected health information to the following: *(Please check and provide the name or specific entities to whom your protected health information may be given.)*

- _____ Family members or friends: _____
- _____ School or Employer: _____
- _____ Other: _____

Patient or Personal Representative's Name Printed _____ Patient or Personal Representative's Signature _____ Date _____

There may be instances that your health care provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another health care provider that may be consulted regarding your care or treatment. Resurgens cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk, and will allow Resurgens Orthopaedics to communicate my PHI electronically.

☐ **Yes** ☐ **No**

This authorization shall be in effect *(please check one).*

- _____ no expiration date
- _____ expiration date of _____

Patient or Personal Representative's Name Printed _____ Patient or Personal Representative's Signature _____ Date _____

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SUMMARY OF PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstance. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader.

Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the full Privacy Notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and/or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager/ Privacy Leader

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PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 4:00pm will not be received until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I am **NOT** allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
5. Narcotics and non-narcotic medications will **NOT** be phoned in after hours or on the weekends.
6. Patients may be terminated from the practice with 30 days notice for noncompliance in the taking of their medications.
7. Resurgens will **NOT** refill prescriptions that have been lost or misplaced.
8. I must keep all appointments as recommended.
9. I will not give, trade or sell medications.
10. The following are conditions for immediate termination from the practice:
    1) Obtaining narcotics from any other physician while under Resurgens' care.
    2) Altering or forging of a prescription. *This is a felony and will be reported.*
11. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive a vehicle you could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. Only one pharmacy may be used for filling prescriptions. My pharmacy's name and location is:

    _____.

    (Please notify us if you change pharmacies.)

    Pharmacy's Phone Number: _____

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me pain medications.

Patient Name: _____
(Please Print)

Patient Signature: _____ **Date:** _____