ALPHA ORTHOPEDICS & SPORTS MEDICINE

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ver 11.15.16

Patient Registration **All Fields Required**

Patients **Legal** Name:			
Date of birth:	Age:	SSN:	
Current Address:			
City:	State:	ZIP Code:	
Marital Status:	Email:		
Cell:	Home:	Work:	Preference: ◯ Cell ◯ Home ◯ Work
Gender:	Race:	Today's Date:	

Employment Information

Patient/Parent's Employer:			
Employer address:		Student:	
City:	State:	ZIP Code:	
Phone:	Occupation:	E-mail:	

Emergency Contact

Name:			
Address:			
City:	State:	ZIP Code:	Phone:
Spouse Name:	Spouse DOB:	Phone:	
Relationship:	Alternative Contact Number:		

Referral

Primary Care Physician (First and Last Name):
How did you hear about us?:
Would you like a copy of your evaluation sent to your Primary Care Physician? ☐ Yes ☐ No

If Patient is a minor Guardian must complete

Parent/Guardian Name:		DOB:
Address:	City:	State:
Zip code:	SSN:	ZIP Code:
Relationship to Patient:	Cell:	Work:

Appointment

May we contact you by phone for appointment reminders? ☐ Yes ☐ No	☐ Home ☐ Work	☐ Both
Is this visit due to an Auto Accident?: ☐ Yes ☐ No	Is this an on the job accident/Injury?: ☐ Yes ☐ No	
Signature of Patient/Guardian:		Date:

Alpha Orthopedics & Sports Medicine

Assignment of Insurance Benefits for Payment from Your Insurance Carrier

Primary	Secondary
Carrier Name:	Carrier Name:
ID#:	ID#:
Group Name/Number:	Group Name/Number:
Ins. Co. Phone #:	Ins. Co. Phone #:
Insured Party Information **(If other than Patient)** Name:	Insured Party Information **(If other than Patient)** Name:
Date of Birth:	Date of Birth:
Address:	Address:
SS #:	SS #:
Relationship to Patient:	Relationship to Patient:

Consent to Release Claims Information and Assignment of Benefits

- I hereby assign, transfer and set over to Alpha Orthopedics all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company(ies).
- I hereby consent for Alpha Orthopedics or any of its employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.
- I understand insurance billing is a service provided as a courtesy and that I am at all times personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to Alpha Orthopedics. I also acknowledge I am responsible for any deductible, copay or other balance not covered by my insurance carrier.
- I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Alpha Orthopedics, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Is your visit today related to an injury that occurred while at work? YES or NO

Is your visit today related to an auto or motorcycle accident? YES or NO

_____ _____

Patient signature (parent/guardian if patient under 18) Date

_____ _____

Patient name (please print) Relationship to patient

Alpha Orthopedics & Sports Medicine – Office Policies

Appointments & Office Hours

- Our office hours are 8:00am to 12:00 pm and 1:30pm to 5:00pm Monday through Friday. The Lobby is closed between noon to 1:30pm daily.
- For urgent matters after 5:00pm, please call our main phone number, 972-838-1635 for the provider on call, however, in an emergency, call 911 or go directly to the nearest emergency room
- **We can only see you for one condition per visit due to increased regulated documentation requirements.**

Financial Policy

- ***Payment is due at time of service. We accept cash, Visa, MasterCard or Discover.***
- For patients with health insurance, co-payments, co-insurance and/or deductibles will be collected at the time services are rendered. Your insurance policy is a contract between you and your insurance company. In the event of denials, errors, service caps, policy exclusions or non-covered services, the patient is responsible for payment of all services rendered. **It is the patient's responsibility to know whether our providers are in-network with their insurance plan.** Patient's will be responsible for any charges incurred whether in or out of network. Please notify the office of any changes in my insurance coverage before services are rendered.
- If you do not have insurance, the office staff can provide you with a cost for services which is due in full, at time of service.
- Any account balance you may have must be paid in full prior to scheduling surgery.
- We reserve the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery.
- If you have multiple primary insurance policies, you are responsible for coordinating primary vs. secondary with your insurance companies. Failure to do so will result in claim denials and refusal to pay.

Auto Accidents/Worker's Compensation

- This office does not accept automobile insurance as a form of payment. We will not accept worker's compensation patients without a claim number, date of injury, case manager and authorization number.
- If you have been in an auto accident or suffered an injury at work, we may ask you to pay upfront at time of service as our claims can be denied to due lack of accident details provided to the insurance company by the patient.

Identity Verification

- If you would like us to bill your insurance carrier, you must present a valid insurance card AND identification prior to being seen at check-in, or payment in full will be required.

Fees for Services

- Medical records: $25.00 for first 30 pages, $.25 each page thereafter. Please allow up to 15 business days.
- Copy of x-rays on disk: $5.00
- Disability, FMLA, employer-related or legal forms are $35.00, per occurrence. (**Our physicians do NOT perform complete disability evaluations for military or worker's compensation reviews.)
- Returned check fee: $35.00 - No Show for Appointment: $50.00 - Notarized Forms: $25.00

Medication Refill Policy

- All requests for prescriptions must be made 48 hours in advance. Please have your pharmacy request your refill. Medication refills are only addressed during office hours. Narcotic prescriptions must be picked up in person and cannot be mailed or called in. *By signing below, you are authorizing us to view your external Rx history.

I have read and understand the Office Policy and I agree to accept responsibility as described above. I also understand the Policy may be amended from time to time by the practice.

_____	_____	_____
Printed Name	Signature	Date

Alpha Orthopedics Physicians Group DBA Alpha Orthopedics & Sports Medicine
Main Office Location
6850 TPC Drive, Suite 116
McKinney, Texas 75070
972-838-1635

Review and Acknowledgement of Notice of Privacy Policies and Practices

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I have reviewed the Notice of Privacy Policies and Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Notice of Privacy Policy	
Patients Name:	Date:
Printed Name of Personal Representative-Parent or Guardian if Applicable:	
Description of Personal Representative Authority:	
Signature of Patient or Guardian:	

Authorization to Disclose Private Healthcare Information

I, _____, do authorize Alpha Orthopedics to provide and discuss all aspects of my private and personal healthcare information with the so indicated individuals that I have designated below. I also authorize Alpha Orthopedics to leave information regarding my personal healthcare on my voicemail or answering machine if so indicated below.

☐ My Spouse: _____

☐ My child/children: _____

☐ My friends(s): _____

☐ On my answering machine or voicemail at the following number(s):_____

☐ Other: _____

I authorize _____ (full legal name) to pick up narcotic prescriptions on my behalf.

Patient Signature: _____ Date: _____

Witness Signature:_____ Date: _____

Name: _____ **DOB:** _____

What are we seeing you for today? _____

Which side is affected? ☐ Right ☐ Left ☐ Both **Was this the result of an accident/injury?** ☐ No ☐ Yes

If yes, please describe <u>in detail</u> what happened: _____

_____

Date pain started? _____ **The pain:** ☐ started suddenly ☐ progressively became worse

The pain is: ☐ constant ☐ intermittent **Does the pain move to other areas?** ☐ No ☐ Yes: _____

Have you had prior surgery at site of pain? ☐ No ☐ Yes **Type of surgery and when?** _____

Severity of pain: ☐ Mild ☐ Moderate ☐ Severe *** **HEIGHT:**_____ **WEIGHT:**_____***

Yes		Yes		Yes	
☐	Bruising	☐	Locking	☐	Tingling in Arms
☐	Cracking Sensation	☐	Night Pain	☐	Tingling in Legs
☐	Decreased Mobility	☐	Night Awakening	☐	Tenderness
☐	Difficult Sleeping	☐	Numbness	☐	Weakness
☐	Instability	☐	Popping	☐	Bleeding
☐	Limping	☐	Spasms	☐	Enlarged Bruise
☐	Redness	☐	Clicking	☐	Warmth
☐	Joint Pain	☐	Grating		
☐	Stiffness	☐	Swelling		

Types of Pain

☐ Aching	☐ Piercing
☐ Burning	☐ Sharp
☐ Dull	☐ Throbbing
☐ Stabbing	☐ Tearing
☐ Shooting	☐ Numbness
☐ Discomfort	
☐ Other _____	

Relieved by

☐ Nothing	☐ Injection	☐ Rest
☐ Brace/Splint	☐ Massage	☐ Stretching
☐ Elevation	☐ Pain/RX Meds	☐ Other_____
☐ Exercise	☐ Mobility	
☐ Heat	☐ OTC Medicines	
☐ Ice	☐ Physical Therapy	

What Makes Symptoms Worse?

☐ Nothing	☐ Movement
☐ Bending	☐ Pushing
☐ Climbing Stairs	☐ Sitting
☐ Standing	☐ Walking
☐ Lifting	☐ Descending Stairs
☐ Kneeling	☐ Other _____

Are you Currently Experiencing these symptoms? (Review of Systems)

☐ Fever	☐ Night Sweats	☐ Fatigue	☐ Headache	☐ Chest Pain	☐ Diarrhea
☐ Nausea	☐ Vision Loss	☐ Cough	☐ Bloody Urine	☐ Constipation	☐ Food Allergies
☐ Irregular Heartbeat		☐ Cold Intolerant Heat Intolerant		☐ Irregular Palpitation	
☐ Environmental Allergies		☐ Difficulty Breathing		☐ Frequent Urination	

Name:	Date:

Surgical History

Procedure/ Surgery	Date

Please list any treatment pertaining to today's complaint (injections, physical therapy, medications…)	

Medications (Include Over-the-counter Medications & Inhalers)

Medication	Dosage	Direction/How Taken

Additional information please write on the back of this page.

Family History

Condition	Family Member	Comments

Additional information please write on the back of this page.

Pharmacy		***All fields required***
Pharmacy Name:	Address:	Phone:

Environmental Allergies: **Drug Allergies:** **Food Allergies:**

○ None	○ None	○ None
○ Latex	○ _____	○ Peanuts
○ Adhesives	○ _____	○ Shellfish
○ Other:	○ _____	○ _____
○ _____	○ _____	○ _____

PAST MEDICAL HISTORY	***All Fields Required***
Name	**Date:**

Have you ever had or currently have:

- ○ **AIDs/HIV**
- ○ **Tuberculosis**
- ○ **Hepatitis**
- ○ Alcoholism
- ○ Alzheimer
- ○ Anemia
- ○ Angina
- ○ Asthma
- ○ Atrial Fibrillation
- ○ Benign Prostatic Hypertrophy
- ○ Cancer
- ○ Congestive Heart Failure
- ○ COPD
- ○ Coronary Artery Disease
- ○ Crohn's Disease
- ○ Depression
- ○ Diabetes
- ○ Drug Abuse (illegal or Rx)
- ○ Deep Vein Thrombosis
- ○ Fibromyalgia
- ○ Gallbladder Disease
- ○ GERD
- ○ Gout
- ○ Heart Attack
- ○ High Cholesterol
- ○ Hypertension
- ○ Ulcerative Colitis
- ○ Juvenile Rheumatoid Arthritis
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lyme Disease
- ○ Migraine Headaches
- ○ Multiple Sclerosis
- ○ Obesity
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Parkinson Disease
- ○ Peptic Ulcer Disease
- ○ Psoriasis
- ○ Peripheral Vascular Disease
- ○ Renal Disease
- ○ Rheumatoid Arthritis
- ○ Scoliosis
- ○ Seizure Disorder
- ○ Sleep Apnea
- ○ Stroke
- ○ Systemic Lupus Erythematous
- ○ Spinal Stenosis
- ○ Spondyloarthropathy
- ○ Traumatic Arthritis
- ○ Thyroid Disease
- ○ Valvular Disease

Social History	**Circle your responses**
Females – Any chance you may be pregnant? : Yes No	Do you live alone or with family?
Receiving Hospice Care?: Yes No	
Activity Level: Low Moderate Active	
Current Smoker ☐ Former Smoker ☐ Non-Smoker ☐	If former how long ago did you quit?
If current how often?:	How many per day: / Interestead in Quiting? Yes No
Do you consume alcohol?: Yes No	How Often: / How Many Drinks?:
Have you ever used illegal drugs?: Yes No	Type: / Currently?
Have you been addicted to prescription medications?: Yes No	Type?:
Do you drink caffeinated beverages? Yes No	How many cups per day?:

Effective Date: March 1, 2014

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.

If you have any questions about this Notice please contact: HIPAA Privacy Officer at 972-838-1635.

This Notice describes how physicians engaged in the private practice of medicine at AOPG, PA facilities (collectively all such physicians are referred to as "Practitioners") may use and disclose your protected health information for purposes of treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. It also describes your rights to access and control your protected health information.

A record of care and services is created in order to manage the care you receive and to comply with certain legal requirements. The Practitioners understand that medical information about you is personal. The Practitioners are committed to protecting medical information about you. The Practitioners are required by law to:

- maintain the privacy of your protected health information;
- provide you with this notice summarizing the Practitioners legal duties and practices related to the use and disclosure of medical information;
- abide by the terms of the notice currently in effect;
- notify affected individuals following a breach of unsecured Protected Health Information.

The Practitioners may dispose of your medical records ten (10) years after the date of your last visit to an AOPG, PA facility, or after applicable periods specified in existing law.

The Practitioners reserve the right to change this notice. The new notice will be effective for all protected health information that the Practitioners possess at that time and that the Practitioners receive in the future. The current notice will be available upon request at AOPG, PA facilities.

1. Protected Health Information – Uses and Disclosures

The following categories describe the types of uses and disclosures of your Protected Health care Information that the Practitioners, their office staff, and their agents may make once you have acknowledged receipt of this notice. For each category of uses or disclosure this notice will explain what is meant and provide some examples. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made as allowed under the law.

Treatment, Including Continuity Of Care: The Practitioners will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your Protected Health Information. For example the Practitioners would disclose your protected health information, as necessary, to a home health agency that provides care to you. The Practitioners will also disclose protected health information to other physicians who may be treating you when you have given the necessary permission to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, the Practitioners may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: The Practitioners may use and disclose medical information about you so that the treatment and services you receive or are provided on your behalf by the Practitioners covered by this Notice may be billed to and payment may be collected from you, an insurance company or a third party. For example, the Practitioners may need to give your health plan information about services you received so your health plan will pay the involved Practitioners or reimburse you for the service. The Practitioners may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. You have the right to request that any disclosures to your health plan made for purposes of receiving payment or to otherwise facilitate healthcare operations be restricted where payment for the service or item at issue has been remitted in full by a person or entity other than the health plan.

Healthcare Operations. The Practitioners may use or disclose, as needed, your protected health information in order to support the business activities of their practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, the Practitioners may disclose your protected health information to their office staff to coordinate your care and records. In addition, the Practitioners may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. The Practitioners may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders. The Practitioners may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Treatment Alternatives and Health-Related Benefits and Services. The Practitioner may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact your Practitioner's office from where you received such material to request, in writing, that these materials not be sent to you.

Fundraising Activities. A Practitioner may use or disclose your demographic information and the dates that you received treatment from your Practitioner, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact your Practitioner's office, in writing, and request that these fundraising materials not be sent to you.

Facility Directories: Unless you sign a document to become a "No Information Patient," the Practitioners may use and disclose in a directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

Individuals Involved in Your Care or Payment for Your Care. The Practitioners may release medical information about you to a friend or family member who is involved in your medical care. The Practitioners may also give information to someone who helps pay for your care. The Practitioners may also tell your family or friends your condition and that you are in the hospital. In addition, the Practitioners may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Emergencies. The Practitioners may use or disclose your protected health information in an emergency treatment situation without your acknowledgment of this Notice. If this happens, an attempt will be made to try and obtain your acknowledgement as soon as reasonably practicable after the delivery of treatment. If a Practitioner is required by law to treat you and the Practitioner has attempted to obtain your acknowledgment but is unable to obtain your acknowledgment, he or she may still use or disclose your protected health information for treatment, payment and operation purposes.

Research. The Practitioner may use or disclose information about you for purposes of research projects approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The Practitioner will almost always ask for your specific permission if they will have access to your name, address or other information that reveals who you are, or will be involved in your care.

Food and Drug Administration. The Practitioner may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required

As Required By Law. The Practitioners will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety.. The Practitioners may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor the Practitioners may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Practitioners may release medical information about you as required by military command authorities. The Practitioners may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation The Practitioners may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Participation in Health Information Exchange. The Practitioners, affiliated hospitals, and/or other healthcare professionals that provide treatment services to AOPG, PA patients may participate in a Health Information Exchange ("HIE"). An HIE allows participating providers secure, immediate electronic access to your pertinent protected health information maintained by participating health care providers as necessary as necessary for treatment. You have the option to "opt-out" of participation in the HIE, precluding your providers from sharing your health information for purposes of treatment. If you have not opted out of the HIE, your protected health information will be available through the HIE to participating health care providers that have a treatment relationship with you, consistent with this Notice of Privacy Practices and the law. If you opt-out of participation in the HIE, your protected health information will not be available through the HIE for your treating providers to search and locate in conjunction with your treatment, but will otherwise continue to be used consistent with this Notice of Privacy Practices and the law. For more information about opting out of the HIE, or for rejoining the HIE subsequent to a previous decision to opt out, you may visit www.ntahp.org,

Public Health Risks. The Practitioners may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Practitioners may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Practitioners may disclose medical information about you in response to a court or administrative order. The Practitioners may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Practitioners may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct in the clinic; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Practitioners may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Practitioners may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Practitioners may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. The Practitioners may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Practitioners may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Uses and Disclosures: Under the law, the Practitioners must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing, except to the extent that a Practitioner or his or her practice has taken an action in reliance on the use or disclosure indicated in the authorization. Examples of the types of uses and disclosures that require a written authorization include: uses or disclosures of psychotherapy notes not subject to specific exceptions defined within applicable regulations; uses and disclosures of Protected Health Information to be used for marketing, unless communication is made face to face or is for a promotional gift of nominal value; uses and disclosures of Protected Information that is a sale of such information as defined within applicable regulations

2. Your Health Information Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to inspect and/or obtain a written or electronic copy of your protected health information. You have the right to inspect and/or obtain a copy of your medical information, as provided by law. Usually this includes medical and billing records but does not include psychotherapy notes. You must submit your request to inspect and/or obtain a copy of your health information in writing to the AOPG, PA facility at which you were treated. Your request to inspect and/or obtain a copy may be denied in certain circumstances and in case of such denial, you may have the right to have this decision reviewed by a health care professional of the Practitioner's choosing. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the facility at which the Practitioner provided you care.

Right to have your physician amend your protected health information. If you feel medical information the Practitioner have about you is incorrect or incomplete, you may request that the information be amended. You must submit a request for amendment to the AOPG, PA facility at which you were treated with a reason supporting your request to amend. The request may be denied if the request is;

- Not in writing
- not supported or corroborated
- to amend information that is accurate or complete
- to amend parts of the information you are not permitted to inspect or copy, by law
- to amend part of the record which is not maintained or was not created by the Practitioner.

For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the AOPG, PA facility at which the Practitioner provided you care.

Right to request a restriction of your protected health information. You may ask a Practitioner not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care, unless provided for by law. The Practitioners are not required by law to agree to a restriction that you may request , unless the request is to restrict a disclosure to a health plan for purposes of payment or operations that relates to a service or item for which you or a source other than the health plan has already remitted payment in full. You may request a restriction by completing a Request for Restrictions form and present it to a registration representative at the AOPG, PA facility at which you were treated for acceptance or denial. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to the health information maintained by the AOPG, PA facility at which the Practitioner provided you care.

Right to request confidential communications. You have the right to request that the Practitioner communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that you only be contacted at work or by mail. Please make this request in writing to a registration representative at the AOPG, PA facility at which you were treated. You will not be asked the reason for your request, and reasonable requests will be accommodated. Your request may also be conditioned on you providing information as to how payment will be handled or specification of an alternative address or other method of contact. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to communications of or with the AOPG, PA facility at which the Practitioner provided you care.

Right to an accounting of disclosures, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations or other allowed disclosures including those to family members or friends involved in your care, as described in this Notice of Privacy Practices. It may also exclude disclosures made based upon a written authorization from you. You have the right to a list of disclosures for time periods no longer than six years and not before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists you may be charged a fee which you will be asked for prior to compiling the list. Please make any requests for a list of disclosures covered by this Notice to the AOPG, PA facility where you were treated, in writing. For purposes of this Notice of Privacy Practices, the right expressed in this provision applies only to disclosures made by the AOPG, PA facility at which the Practitioner provided you care.

Right to obtain a paper copy of this notice . Upon request, the Practitioner office will provide you with a paper copy of this notice, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to a Practitioner, to the AOPG, PA facility were the Practitioner provided you care, or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by the Practitioner. You may file a complaint with the Practitioner by notifying your Practitioner or with the facility by notifying AOPG, PA, HIPAA Privacy Officer, 6850 TPC Drive, Suite 116, McKinney, TX 75070, of your complaint. All complaints must be in writing, and you will not be retaliated against for filing a complaint.

You may contact our Privacy Officer at 972-838-1635.

This notice was published and becomes effective on March 1, 2014.

ALPHA ORTHOPEDICS
& SPORTS MEDICINE

N O T I C E – Effective 10/6/2014

HYDROCODONE & HYDROCODONE COMBINATION DRUGS CLASSIFICATION CHANGE

The U.S. Drug Enforcement Administration (DEA) has announced that hydrocodone and hydrocodone combination products will be reclassified from Schedule III to Schedule II effective October 6, 2014.

As of October 6, 2014, hydrocodone and hydrocodone combination prescriptions and refills will no longer be able to be processed electronically or via telephone. Prescriptions will require a physician signature and will be required to be written on a prescription pad.

WHAT DOES THIS MEAN FOR YOU?

- These prescriptions will not have pre-authorized refills.
- You will need to obtain all prescriptions for these medications in person from your Physician.
- Prescriptions will only be written during normal business hours, Monday through Friday.
- Prescriptions will not be written on weekends or holidays when the clinic is closed.

HOW YOU CAN HELP

- Plan ahead – Don't wait until you are out of medication to call your physician.
- Don't wait until you are out of medication to call your Physician.
- Call our medication refill line and allow at least 48 HOURS for us to prepare your prescription. Prescriptions must be picked up.
- We cannot accommodate walk-in refill requests.
- We encourage you to discuss this change with your Physician and discuss alternative pain medication options that may be authorized electronically or by telephone.

Refills for prescriptions for hydrocodone and combination hydrocodone products written and approved prior to October 6, 2014 may be dispensed by your Pharmacist from that prescription until April 8, 2015.

We understand the difficulty this will cause our patients in obtaining these types of prescriptions; however, we are mandated to comply with the new DEA regulations.

_____ _____

Patient Name Person(s) authorized to pick up prescription at clinic

_____ _____

Patient Signature Date Person(s) authorized to pick up prescription at clinic

_____

Person(s) authorized to pick up prescription