

Name: \_\_\_\_\_

Chart: \_\_\_\_\_

**TOS Health Questionnaire**

Date: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family Physician \_\_\_\_\_

Main Reason for Medical Evaluation \_\_\_\_\_

Date of Injury/Length of symptoms: \_\_\_\_\_ Where did injury occur? \_\_\_\_\_

Is this a *work related* problem? Y N Are you right or left handed? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

What treatment have you received for this problem? \_\_\_\_\_

1. Medications: \_\_\_\_\_ 2. Physical Therapy (**location**): \_\_\_\_\_

3. Injections (**when**): \_\_\_\_\_ 4. Surgery: \_\_\_\_\_

4. X-rays (**where & when**): \_\_\_\_\_ 6. MRI (**where & when**): \_\_\_\_\_

7. Brace/Walking Aids: \_\_\_\_\_ 8. Other: \_\_\_\_\_

**Have you ever been diagnosed with any of the following conditions: Check all that apply.**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Sleep Apnea     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Stomach Ulcers  |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> GI Bleeding         | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sickle Cell Disease  |  |

Are any other physicians treating you for ANY health problems? \_\_\_\_\_

If yes, whom? \_\_\_\_\_

Have you had any heart testing? Y N if yes, when and where? \_\_\_\_\_

Have you ever had **Blood Clots**? \_\_\_\_\_

Did you have any adverse reaction to anesthesia? \_\_\_\_\_

Smoking Status?  Never smoker  Current everyday smoker: \_\_\_\_\_ Year started smoking  
 Current some day smoker: \_\_\_\_\_ Year started  Former smoker: \_\_\_\_\_ Year started \_\_\_\_\_ Year quit

Do you drink alcohol:  None  Beer  Liquor  Wine Amount: \_\_\_\_\_

Marital status: S M D W Hobbies: \_\_\_\_\_

**Have you recently had any of the following problems/symptoms: Check any which apply.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Easy bruising                    | <input type="checkbox"/> Lumps/Masses                |
| <input type="checkbox"/> Alcohol addiction      | <input type="checkbox"/> Excessive thirst                 | <input type="checkbox"/> Nausea or vomiting          |
| <input type="checkbox"/> Balance problems       | <input type="checkbox"/> Fainting spells                  | <input type="checkbox"/> Numbness/Tingling/Weakness  |
| <input type="checkbox"/> Blood in stool         | <input type="checkbox"/> Fever or chills                  | <input type="checkbox"/> Other joint symptoms        |
| <input type="checkbox"/> Blood in urine         | <input type="checkbox"/> Gait disturbance/Walking changes | <input type="checkbox"/> Pain burning with urination |
| <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Headaches/Migraines              | <input type="checkbox"/> Palpitations                |
| <input type="checkbox"/> Chest pain             | <input type="checkbox"/> Hearing Loss                     | <input type="checkbox"/> Rectal bleeding             |
| <input type="checkbox"/> Chronic cough          | <input type="checkbox"/> Heartburn                        | <input type="checkbox"/> Sexual dysfunction          |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Hoarseness                       | <input type="checkbox"/> Shortness of breath         |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Hot or cold intolerance          | <input type="checkbox"/> Skin rashes or sores        |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Loss of appetite                 | <input type="checkbox"/> Trouble swallowing          |
| <input type="checkbox"/> Drug addiction         | <input type="checkbox"/> Loss of control of bladder       | <input type="checkbox"/> Unexplained weight loss     |
| <input type="checkbox"/> Easy bleeding          | <input type="checkbox"/> Loss of control of bowels        | <input type="checkbox"/> Vision Problems             |
| <input type="checkbox"/> Other: _____           |   |  |

Name:

Chart:

**TOS Health Questionnaire**

Date:

**Family History:**

Father    Mother    Sibling

Father    Mother    Sibling

High Blood Pressure:

Diabetes:

Heart Disease:

Bleeding Problems:

Cancer:

Lung Disease:

Arthritis:

Reaction to Anesthesia:

Blood Clots:

Other: \_\_\_\_\_

**Do you have issues with activities of daily living? Check all that apply.**

- Getting in and out of bed
- Getting dressed
- Putting on shoes

- Getting in and out of the car
- Getting in and out of the tub/shower
- Other: \_\_\_\_\_

Please list any current prescriptions and non-prescription medication and dosages:

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Please list any allergies:

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Please list any surgeries you have had and dates:

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Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Review \_\_\_\_\_ Date \_\_\_\_\_

Name:  
Chart:  
Date:

**Toledo Orthopaedic Surgeons Patient Data Sheet**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
SS# \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
(Street) \_\_\_\_\_ Cell Phone \_\_\_\_\_  
(City) (State) (Zip Code)  
Race: American Indian  Asian  Black  Native Hawaiian  White  Other  Unknown   
Ethnicity: Hispanic  Non-Hispanic  Unknown  Preferred Language \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Referring MD \_\_\_\_\_ Primary Care MD \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Guarantor's Name and Address (if different from patient's) \_\_\_\_\_  
(City) (State) (Zip Code)  
Emergency Contact (other than spouse) \_\_\_\_\_  
Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**INSURANCE INFORMATION (We will ask to make a copy of your card)**

**Primary Insurance Carrier** \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_  
**Policy Holder's Identification Number** \_\_\_\_\_  
Policy Holder's SS# \_\_\_\_\_ Employer \_\_\_\_\_  
**Secondary Insurance Carrier** \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_  
**Policy Holder's Identification Number** \_\_\_\_\_  
Policy Holder's SS# \_\_\_\_\_ Employer \_\_\_\_\_

**Consent to Release Medical Information / Assignment of Benefits**

**\*\*SIGNATURE REQUIRED\*\***

I hereby consent to the use and disclosure by TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, inc. of medical information to carry out medical treatment, payment, and health care operations as defined by applicable law. **Medical treatment** includes the provision, coordination, and management of my health care and related services, including treatment by TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc. and other physicians, hospitals, and providers of medical services and/or their agents to whom I may be referred (and any referring and primary care/family physicians which have been or may be involved in my care and treatment). **Payment** includes all activities relating to the determination of coverage and reimbursement for the provision of health care services, and related claims management and review activities. **Health care operations** include activities of Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. relating to medical care and treatment and related assessment, quality improvement, and management activities.

I agree that Toledo Orthopaedic Surgeons may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I authorize my insurance benefits to be paid directly to TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc., realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans. Unpaid accounts sent to collection agency will incur a fee.

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

X \_\_\_\_\_  
PATIENT'S (OR RESPONSIBLE PARTY'S) SIGNATURE DATE

**\*\*MEDICARE PATIENT'S ONLY\*\***

I request that payment of authorized Medicare benefits be made to me or on my behalf to the physicians of TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc., for any service furnished to me by the physicians. I authorize release to the Health Care Financing Administration and its agents any medical information about me needed to determine the payments for related services.

X \_\_\_\_\_  
SIGNATURE OF BENEFICIARY DATE

Name:  
Chart:  
Date:

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Ashok Biyani, MD  
Spine  
Toledo Orthopaedic Surgeons

Patient questionnaire

Please answer all questions as directed to help us evaluate and treat your problem.

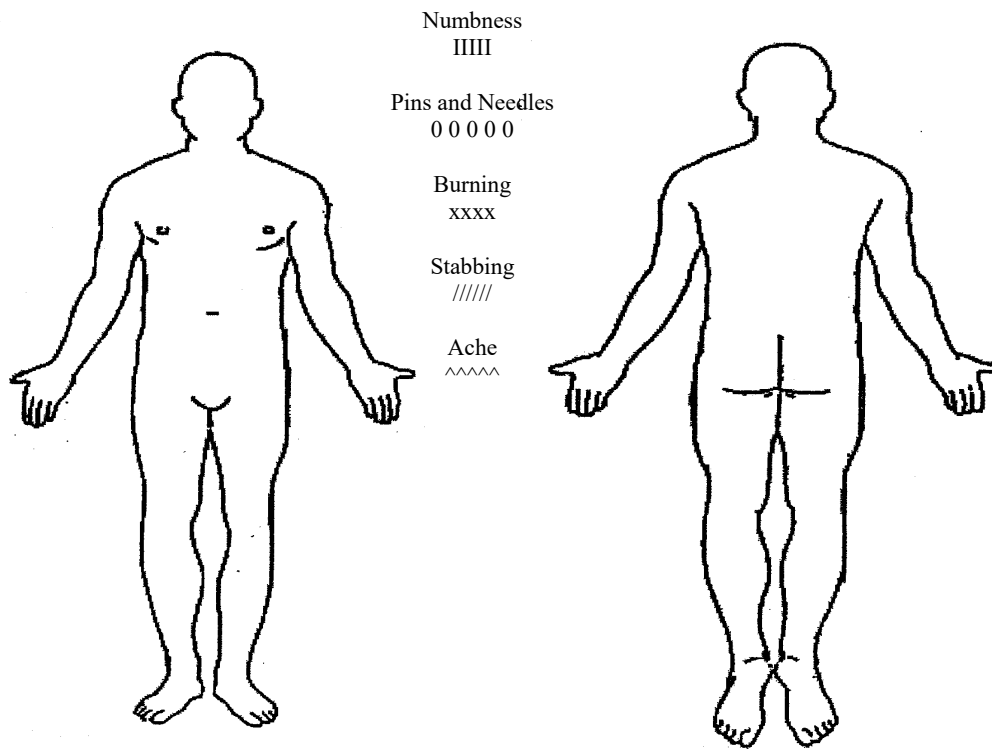
---

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

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Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



Name: \_\_\_\_\_

Chart: \_\_\_\_\_

Date: \_\_\_\_\_

---

When did your pain start? \_\_\_\_\_

How did your pain start? (check appropriate box)

- Suddenly                       Gradually  
 Pulling                       Lifting                       Twisting                       Fall                       Bending  
 Injured at work                       Injured in auto accident                       Injured during sports  
 No apparent cause

**Back pain** \_\_\_\_\_

**Neck pain** \_\_\_\_\_

Severity of pain at its worst \_\_\_\_\_ at its best \_\_\_\_\_ (1-10, 10 being the worst)

- Progress:             Improving             Same             Getting worse  
Nature:             Sharp             Dull             Burning             Numbness             Pins and needles

What affects your pain?

- Worse with             standing             walking             sitting             laying             no difference  
Better with             standing             walking             sitting             laying             no difference  
Worse with             coughing             sneezing  
Worse in the             morning             afternoon             evening             in bed

Pain in the leg            R / L / both    Pain in the arm            R / L / both

Severity of pain at its worst \_\_\_\_\_ at its best \_\_\_\_\_ (1-10, 10 being the worst)

Radiation

- Leg pain             to the hips/thighs             below the knees             toes  
Arm pain             to the shoulder             elbow             fingers

Weakness in legs / arms \_\_\_\_\_

How far can you walk? \_\_\_\_\_ block(s), \_\_\_\_\_ mile(s)

Can you sleep well at night? \_\_\_\_\_

Bowel or bladder problems \_\_\_\_\_

Have you had back or neck pain in the past? Yes / No.    When \_\_\_\_\_

Have you had any treatment so far?     Yes     No            If yes, answer the following:

- physical therapy             pain management             aqua therapy  
 chiropractic

Any prior spine surgery \_\_\_\_\_    When and by whom \_\_\_\_\_

If female over 67 years old - Have you had a bone density study (DEXA)?  Yes     No

Are you taking any medications for osteoporosis?     Yes     No

**Previous studies**

- X-rays                       Nerve conduction / EMG                       MRI / CT scan / myelogram

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Name and signature of person completing the form

Date

Name: \_\_\_\_\_

Chart: \_\_\_\_\_

Date: \_\_\_\_\_

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### Toledo Orthopaedic Surgeons Division

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**I wish to be contacted in the following manner (check all that apply):**

**Oral Communication:**

- |   |   |
|---|---|
| <input type="checkbox"/> Home telephone                                   | <input type="checkbox"/> Work telephone                                   |
| <input type="checkbox"/> O.K. to leave message with detailed information. | <input type="checkbox"/> O.K. to leave message with detailed information. |
| <input type="checkbox"/> Leave message with call-back number only.        | <input type="checkbox"/> Leave message with call-back number only.        |
| <input type="checkbox"/> Other _____                                      |   |

**Written Communication:**

- |   |   |
|---|---|
| <input type="checkbox"/> O.K. to mail to my home address        | <input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> O.K. to mail to my work/office address | <input type="checkbox"/> Other _____                      |

**Email Communication:**

My email address is: \_\_\_\_\_

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**I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:**

- |  |              |
|--|--------------|
| <input type="checkbox"/> Spouse's name: _____                | Phone: _____ |
| <input type="checkbox"/> Adult child(ren) name: _____        | Phone: _____ |
| <input type="checkbox"/> My parent(s) name: _____            | Phone: _____ |
| <input type="checkbox"/> Personal representative name: _____ | Phone: _____ |

**If checked, the following additional instructions apply:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

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**If signed by patient's authorized representative, describe the representative's authority:**

- Patient is a minor; I am the patient's parent and natural guardian.
- Patient is a minor; I am the patient's guardian, appointed by the \_\_\_\_\_ County Juvenile Court.
- Patient is a ward; I am the patient's guardian, appointed by the \_\_\_\_\_ County Probate Court.
- The patient is deceased. I am the patient's surviving spouse.
- The patient is deceased. I am the executor or administrator of the patient's estate, appointed by the \_\_\_\_\_ County Probate Court.
- I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- Other (describe) \_\_\_\_\_

Name:

Chart:

Date:

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## Toledo Orthopaedic Surgeons

### Preferred Pharmacy Information

In an effort to serve you better, we are now able to send prescriptions electronically. This process will help reduce medication errors and reduce the time you have to wait for a prescription to be filled. In order to do this efficiently, please complete the information below. Please know that this form does not obligate you to use this pharmacy; it simply allows us to prepare your chart so that your information is readily available to your physician.

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

Name:

Chart:

Date:

---

**Toledo Orthopaedic Surgeons  
Bureau of Worker's Compensation Declaration  
NON-Work Related Injuries**

**PLEASE READ CAREFULLY.** By signing below, you are declaring that the injury or disease for which your Toledo Orthopaedic Surgeon physician is treating you *is not a work related injury, and that it did not occur while you were on the job or executing a work related activity.*

Further, you understand that we will not support this injury or disease as a work related injury.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Bureau of Worker's Compensation Declaration  
Work Related Injuries**

**PLEASE READ CAREFULLY:** By signing this form, you are declaring that the injury or disease for which your Toledo Orthopaedic Surgeon is treating you *is a work related injury, and that it occurred while you were on the job or executing a work related activity.*

I hereby declare that my injury is work related and I authorize Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. to submit a claim with complete information to my Workers' Compensation insurance carrier for covered services rendered by my physician at Toledo Orthopaedic Surgeons. I authorize my Workers' Compensation insurance to issue payment directly to Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. for all payable services. I understand that I am financially responsible to Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. for all charges to the extent they are not covered by insurance, unless otherwise prohibited by applicable State of Ohio law.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer at Time of Injury \_\_\_\_\_

Address of Employer \_\_\_\_\_

Is your employer disputing your claim? \_\_\_\_\_ Is your claim in litigation? \_\_\_\_\_

Description of how injury occurred \_\_\_\_\_

\_\_\_\_\_

Is this a **possible** worker's comp claim? \_\_\_\_\_ Are you filing a claim? \_\_\_\_\_

**\*\*\*Please Note\*\*\* We will need to make a copy of your black and white identification card from BWC, as well as your health insurance card. In the event your claim is disallowed, your health insurance will be billed. Please remember you are ultimately responsible for all payment of all charges.**



Name:

Chart:

Date:

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## CONTRACT FOR CONTROLLED-SUBSTANCE PRESCRIPTIONS

When used appropriately, controlled substances, such as narcotics and tranquilizers, are safe and useful medications. These drugs can control pain and improve function. In many cases, they allow people to resume fairly normal lives. However, these drugs are frequently abused in our society. In order for Toledo Orthopaedic Surgeons to comply with State and Federal regulations, it is necessary to ask you to agree to the following conditions before any of these types of medications can be prescribed for you.

1. I am responsible for my controlled-substance medication. If the prescription or medication is lost or stolen, or if I use it up sooner than prescribed, I understand that it will NOT be replaced. I am responsible to take the medication as prescribed and keep track of the number of doses remaining.
2. I will not request or accept controlled-substance medications from any other physician while I am receiving such medication from any physician of Toledo Orthopaedic Surgeons. The only exception is if a controlled substance is given while I am admitted to a hospital.
3. I can request refills for my controlled-substance medication ONLY DURING REGULAR OFFICE HOURS. I understand that refills WILL NOT BE AVAILABLE AT NIGHT, ON WEEKENDS, OR ON HOLIDAYS, AS THE ON-CALL PHYSICIAN DOES NOT HAVE ACCESS TO MY MEDICAL RECORDS.
4. I understand that I must select and use one pharmacy where I will have my prescriptions filled. If I move or my insurance changes that would require a change in pharmacy, I will notify the staff of Toledo Orthopaedic Surgeons of the reason for the change should it happen.
5. IN THE EVENT THAT WE DISCOVER THAT YOU ARE RECEIVING PRESCRIPTIONS FOR PAIN MEDICATIONS FROM OTHER PHYSICIANS, OUR OFFICE WILL IMMEDIATELY DISCONTINUE ANY FUTURE PRESCRIBING OF ANY MEDICATIONS.
6. I understand that refills for any medication require a 48-hour notice. I understand that requests for "emergency" refills, such as on a Friday afternoon when I suddenly realize that I will "run out tomorrow", will most likely not be honored.
7. I understand that refills for any type of pain medication will only be considered for patients who are under "current treatment". Each prescription will be for a fixed amount of medication sufficient to last until the next visit and this WILL NOT be increased.

I UNDERSTAND THAT IF I VIOLATE ANY OF THESE CONDITIONS, MY CONTROLLED SUBSTANCE PRESCRIPTIONS MAY BE ENDED IMMEDIATELY.

I have read and understand the above policy and agree to abide by these conditions.

---

Signature

---

Date

Name:

Chart:

Date:

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**Toledo Orthopaedic Surgeons Division**  
**Notice of Privacy Practices**

**THIS NOTICE, WHICH IS EFFECTIVE AS OF April 14, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

The doctors and staff here at **Toledo Orthopaedic Surgeons Division** believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes your rights concerning our use of your health information.

**We will use and disclose your health information for purposes of treatment, payment and/or health care operations.**

1. **Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. *For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.*
2. **Payment** means activities undertaken by a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care. *For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.*
3. **Health Care Operations** includes certain activities of the practice, as well as activities of an organized health care arrangement in which we participate, including; quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and business management and planning. *For example, from time to time hospitals and insurance companies will review physicians' clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary for the reviewer to randomly select and examine patients' medical records.*

**We are permitted or required to disclose limited health information about you, without your authorization, in the following circumstances:**

1. **As required by law** so long as it is limited to the relevant requirements of such law.
2. **For public health activities**, including the prevention and control of disease, vital statistics, and public health investigations.
3. For purposes of making required reports about **victims of abuse, neglect or domestic violence.**
4. **Health oversight activities**, including audits, civil, criminal or administrative investigations, proceedings or actions; inspections; licensure or disciplinary actions.
5. **Judicial and administrative proceedings**, in response to court orders.
6. **Law enforcement purposes** (i.e., reports of gunshot wounds; grand jury subpoenas; and information regarding victims of crime).
7. **To coroners, medical examiners and funeral directors** for purposes of identifying deceased persons or determining cause of death.
8. **For organ and tissue donation**, consistent with applicable laws.
9. **Research**, provided the federal regulations governing research activities that insure the privacy of your health information are met.
10. **To avert serious threats to health or safety.**
11. **Specialized government functions** regarding military personnel and military veterans, certain national security purposes, and inmates.
12. **Workers' compensation** to the extent necessary to comply with applicable laws.
13. **Marketing**, for purposes of appointment reminders, treatment alternatives, or other related benefits and services that may be of interest to you.

**Any uses or disclosures other than those noted above require us to obtain your written authorization, which you may revoke at any time. Any such revocation must be in writing.**

(over)

Name:

Chart:

Date:

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**You have the following rights with respect to your health information:**

1. The right to request restrictions on certain uses of your health information, **however we are not required to agree to your request.**
2. The right to request, in writing, the manner or method by which we contact you to furnish confidential communications about your health information (i.e., fax, e-mail, voice mail, etc.). You are obligated to notify us, in writing, of any changes to your request.
3. The right to inspect your health information (you are entitled to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in, a civil, criminal, or administrative action or proceeding).
4. In limited circumstances, the right to ask us to amend your health information, **however we reserve the right to deny your request.** If your request to amend is denied, we will provide you with information about the basis of our denial and your right to submit a written statement disagreeing with our denial.
5. The right to receive an accounting of disclosures of your health information, except those disclosures related to treatment, payment or health operations, disclosures that are made to you, disclosures made for national security purposes or to correctional institutions or law enforcement officials, or disclosures that were made prior to the compliance date.
6. The right to receive a copy of this Notice in writing.

**We have the following obligations:**

1. We are required by law to maintain the privacy of your health information, and we are required to provide you with a notice of our legal duties and privacy practices.
2. We are required to abide the terms of the notice.
3. We are required to advise you of any changes we make in the terms of our notice of privacy practices. If any changes are made to notice of privacy practices, we will post the revised notice and make a copy of it available on request.

**Complaints**

If you believe we have violated your privacy rights, you may file a written complaint to our Privacy Officer and/or to the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

If you want more information or you believe your rights have been violated, you can contact Our Privacy Officer at the following address: Toledo Orthopaedic Surgeons Division. 2865 N. Reynolds Rd., Building A. Toledo. Ohio 43615-2100. Attention Privacy Officer. Our telephone number is 419-578-7200. Alternatively, you may wish to contact the federal agency in charge of enforcing patients' privacy rights. That address is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHS Building. Washington, D.C. 20201.

**Acknowledgment**

I have read the foregoing Notice of Privacy Practices provided to me by Toledo Orthopaedic Surgeons Division, and I have been given the opportunity to discuss the privacy practices at Toledo Orthopaedic Surgeons Division. I understand that the practice may, at its discretion, change the terms and conditions of this Notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of same.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Staff initials

If signed by patient's authorized representative, describe the representative's authority:

- Parent of minor child     Guardian     Agent (Health Care Power of Attorney)     Other (describe)

\_\_\_\_\_  
The Notice of Privacy Practices was provided to \_\_\_\_\_, however he/she did not acknowledge receipt for the following reason:     Refused     Did not understand     Other

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date