Clinic Patient Information Record

HAVE YOU BEEN TO RIVER CITIES INTERVENTIONAL PAIN SPECIALISTS IN THE LAST 3 YEARS? { } YES { } NO

Patient Name/Last:	**First:**	**Middle:**	**SSN:**	
Date of Birth/Month: **Day:** **Year:**	☐ **Male** ☐ **Female**	**Race:**	**Ethnicity:**	☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**
Residence Address:	City:		State:	Zip:
Mailing Address: (Check here if same as above) ☐				
Home Telephone Number:	Cell Phone Number:		Email Address:	
Employer's Name:		Work Telephone Number:		Ext:
Preferred Language: ☐ English ☐ Spanish ☐ Other Communication Needs		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Responsible Party: (check here if same as above) ☐				
Name/Last:	First:	Middle:	Responsible party's SSN:	Date of birth:
Mailing Address:	City:		State:	Zip:
Home Telephone Number:		Relationship to Patient:		
Employer's Name:		Work Telephone Number:		Ext:
Responsible Party's Spouse's Name (if applicable):			SSN:	
In Case of an Emergency, who may we notify? (Other than someone living with you)			Relationship to Patient:	
Name:	Date of Birth:		Telephone Number:	
Address:	City:		State:	Zip:
Who referred you to our office? { } Insurance { } ROC Patient/Friend/Family { } Employer { } High School/Sport { } Hospital/Urgent Care { } Magazine/Newspaper { } Physician { } Radio/Television { } Website/Online				
REFERRAL INFORMATION				
Primary Care Physician:		Referring Physician:		
Insurance Coverage	Is your Illness/injury due to an Auto/Work Accident?		Yes ☐	No ☐
Insurance #1 Name of Insurance Company:				
Policy Number		Group Number:		
Employer:		Subscriber: Relation to Patient:		
Insurance # 2 Name of Insurance Company:				
Policy Number		Group Number:		
Employer:		Subscriber: Relation to Patient:		

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while ROC contracts with many insurance companies, it is my responsibility to verify with my plan that ROC is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize ROC to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo IDs taken are used to assist I patient recognition per HIPAA guidelines.

Patient/Guardian Signature _____ Date _____

Medical History			
Patient Name:		**DOB:**	**Date:**
Preferred Pharmacy:		**Location:**	
Referring MD:		**PCP:**	
[ ] Right-Handed	**[ ] Left-Handed**	**Height:**	**Weight:**

History of Present Illness	
Are you here for a new injury or a CHRONIC problem?	[ ] New injury [ ] Chronic problem
Is worker's compensation or personal injury attorney involved? [ ] Yes [ ] No	Date of Injury: Where did injury occur?
	How did the injury occur?

Evaluation Of Pain / Discomfort

Which body part is affected, including side?

Have you had similar symptoms before?

When does the problem occur? [ ] constant [ ] activity-related [ ] intermittent, not related to activity

What makes it feel better?

What makes it feel worse?

Pain feels like: [ ] Throbbing [ ] Stabbing [ ] Burning [ ] Shooting [ ] Sharp [ ] Dull [ ] Ache [ ] N/A - describe:

Pain Scale: | **Mild** **Moderate** **Severe** |

1 2 3 4 5 6 7 8 9 10

Associated symptoms: [ ] Popping [ ] Locking [ ] Clicking [ ] Numbness [ ] Giving way [ ] Redness/Bruising [ ] Swelling [ ] N/A

Does the pain wake you from sleep? [ ] Yes [ ] No

Previous Treatment For This Problem

Diagnostic Testing: [ ] X-Ray [ ] CT [ ] MRI [ ] EMG [ ] Other:

Medications used for **THIS** problem:

Anti-inflammatories helpful? [ ] Yes [ ] No [ ] N/A | Chiropractic's helpful? [ ] Yes [ ] No [ ] N/A

Injections helpful? [ ] Yes [ ] No [ ] N/A | Acupuncture helpful? [ ] Yes [ ] No [ ] N/A

Physical therapy helpful? [ ] Yes [ ] No [ ] N/A Where?

Other treatment for this injury?

Have other doctors seen you for this condition? [ ] No [ ] Yes - Whom? [ ] ER Location:

Past Medical History

[ ] I have no significant past medical history

OR...I have a history of one or more of the following:

[ ] Eye Disease

[ ] Asthma
[ ] COPD
[ ] Emphysema
[ ]Tuberculosis
[ ]Sleep Apnea

[ ] Angina
[ ] Heart Disease
[ ] Heart Attack
[ ] High Cholesterol
[ ] Hypertension
[ ] Mitral Valve Prolapse

[ ] AIDS/HIV
[ ] Anemia
[ ] Bleeding Disorders
[ ] Blood Clots
[ ] Hemophilia
[ ] MRSA
[ ] Sickle Cell Disease

[ ] Bowel Disease
[ ] GERD
[ ] Hiatal Hernia
[ ] Kidney Disease
[ ] Urinary Tract Infection

[ ] Cancer
Type:

[ ] Cerebral Palsy
[ ] Meningitis
[ ] Migraine Headaches
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Polio
[ ] Seizure Disorder
[ ] Spina Bifida
[ ] Stroke

[ ] Back Problems
[ ] Fibromyalgia
[ ] Muscular Diseases
[ ] Scoliosis

[ ] Gout
[ ] Osteoarthritis
[ ] Osteoporosis
[ ] Rheumatoid Arthritis

[ ] Hepatitis { }A { }B { } C
[ ] Liver Disease

[ ] Alcohol Abuse
[ ] Anxiety
[ ] Bipolar Disorder
[ ] Depression
[ ] Drug Abuse
[ ] Mental Disability

[ ] Diabetes – A1c ___
[ ] Lupus
[ ] Thyroid Disease

[ ] Anesthesia Complications
[ ] Malignant Hyperthermia

Other:

Current Medications

[ ] I am not currently taking any medications.
*** ***Or please prepare a list of medications to give to the nursing staff when they interview you.***

- Do you take a blood thinner? [ ] Yes **[ ]** No
- **Have you had ANY steroids (oral or injection) in the last 90 days (3 months)? [ ] Yes [ ] No**
- Do you have any metal in your body? [ ] Yes [ ] No Are you claustrophobic? [ ] Yes [ ] No

Allergies

[ ] I have no known medical allergies of which I am aware.
*** *Or I am allergic to the following:*

Reaction	*Reaction*	*Reaction*
[ ] Adhesive	[ ] Dilaudid	[ ] Macrobid
[ ] Amoxicillin	[ ] Doxycycline	[ ] Morphine
[ ] Aspirin	[ ] Erythromycin	[ ] Naprosyn
[ ] Augmentin	[ ] Vicodin	[ ] Oxycodone
[ ] Bactrim	[ ] Ibuprofen	[ ] Penicillin
[ ] Bee Sting	[ ] Iodine	[ ] Shellfish
[ ]Benadryl	[ ] Keflex	[ ] Statins
[ ] Codeine	[ ] **Latex**	[ ] Sulfa
[ ] Contrast Dye	[ ] Levaquin	[ ] Tetracycline
[ ] Demerol	[ ] Lisinopril	[ ] Tramadol
[ ] Other	[ ] Other	[ ] Other

Past Surgical History

[ ] I have had no significant past surgeries. (*Example: Spine/back, hand/wrist, foot/ankle, hip or any other orthopedic/musculoskeletal surgeries)*
*** *Or the surgeries I have had are:*

Family Medical History

[ ] I have no significant family medical history [ ] Unknown
*** *Or my family has a history of:*

[ ] Arthritis	[ ] Bleeding Disorder	[ ] Blood Clot	[ ] Cancer	[ ] Diabetes
[ ] Epilepsy	[ ] Heart Disease	[ ] Hypertension	[ ] Kidney Disease	[ ] Lung Disease
[ ] Mental Illness	[ ] Muscle Disease	[ ] Osteoporosis	[ ] Scoliosis	[ ] Stroke
[ ] Anesthesia Complications				

Other:

Social History

Smoking Status: [ ] Never [ ] Ex-Smoker [ ] Smoker **Type:** [ ] E-Cigarette [ ] Cigarette [ ] Pipe [ ] Cigar [ ] Smokeless [ ] Chew
*** If quit - When:
How often do you drink Alcohol: [ ] Never [ ] Occasionally [ ] Frequently [ ] Heavily

Occupation: _____

Review Of Systems

[ ] I have no current issues other than the reason I am being seen.
*** *Or I am currently having problems with the issue(s) selected below:*

Unexplained Weight Loss	[ ] Yes	[ ] No	[ ] Unsure	Cough	[ ] Yes	[ ] No	[ ] Unsure
Fever	[ ] Yes	[ ] No	[ ] Unsure	Wheezing	[ ] Yes	[ ] No	[ ] Unsure
Chills	[ ] Yes	[ ] No	[ ] Unsure	Shortness of Breath	[ ] Yes	[ ] No	[ ] Unsure
Fatigue	[ ] Yes	[ ] No	[ ] Unsure	Chest Pain	[ ] Yes	[ ] No	[ ] Unsure
Night Sweats	[ ] Yes	[ ] No	[ ] Unsure	Palpitations	[ ] Yes	[ ] No	[ ] Unsure
Double Vision/Blackouts/Headaches	[ ] Yes	[ ] No	[ ] Unsure	Leg/Feet Swelling	[ ] Yes	[ ] No	[ ] Unsure
Blurred Vision	[ ] Yes	[ ] No	[ ] Unsure	Swelling/Redness in Joints	[ ] Yes	[ ] No	[ ] Unsure
Difficulty Hearing	[ ] Yes	[ ] No	[ ] Unsure	Easy Bruising	[ ] Yes	[ ] No	[ ] Unsure
Pain/Ringing in Ears	[ ] Yes	[ ] No	[ ] Unsure	Seizures	[ ] Yes	[ ] No	[ ] Unsure
Swollen Neck Glands	[ ] Yes	[ ] No	[ ] Unsure	Dizziness	[ ] Yes	[ ] No	[ ] Unsure
Abdominal Pain/Nausea/Vomiting	[ ] Yes	[ ] No	[ ] Unsure	Balance Problems	[ ] Yes	[ ] No	[ ] Unsure
Trouble Swallowing	[ ] Yes	[ ] No	[ ] Unsure	New Headaches	[ ] Yes	[ ] No	[ ] Unsure
Change in Bowel Habits	[ ] Yes	[ ] No	[ ] Unsure	Depression	[ ] Yes	[ ] No	[ ] Unsure
Constipation/Diarrhea Blood in Stool	[ ] Yes	[ ] No	[ ] Unsure	Anxiety	[ ] Yes	[ ] No	[ ] Unsure
Painful Urination	[ ] Yes	[ ] No	[ ] Unsure	Itching/Rashes Sore/Bleeding Mole	[ ] Yes	[ ] No	[ ] Unsure
Sense of Full Bladder	[ ] Yes	[ ] No	[ ] Unsure				
Difficulty Urinating	[ ] Yes	[ ] No	[ ] Unsure				
Blood in Urine	[ ] Yes	[ ] No	[ ] Unsure				

Patient Signature_____ **Date**_____

Privacy and Disclosure Statement

Your treatment, payment, enrollment or eligibility for benefits at Rapid Orthopaedic Care ("ROC") is not dependent upon whether you sign this Privacy and Disclosure statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation on ROC at 1549 E 70th St #300, Shreveport, LA 71105, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these acknowledgments and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of ROC which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt-out of receiving text message reminders, I am responsible for changing my preferred method of contact with ROC.

I hereby agree that ROC may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient/Patient's Representative: _____ Date: _____

Printed Name of Patient/Patient's Representative: _____

Financial Policy

Rapid Orthopaedic Care ("ROC") places its patients' needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at ROC. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance and non-covered services are to be paid at or before the time of service. ROC accepts cash, checks, major credit cards, debit cards, and HSA/FSA.
- I understand that I may be contacted by telephone regarding my outstanding balance with ROC.
- I understand that if I do not have my insurance and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand that ROC will collect, prior to any procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and ROC. If the full deductible is not applied to your claim by your insurance company, ROC will refund any overpayment to you when we receive overpayment.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that there may be fees associated with medical records requests. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

CONSENT TO TREAT

Thank you for choosing Rapid Orthopaedic Care as your health care provider. The following is a statement of our Release of Information, Financial, and Medical Policies which we require you to read and sign prior to any treatment.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Rapid Orthopaedic Care rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION-For Billing Purposes: I hereby authorize Rapid Orthopaedic Care to release medical information to Medicare, my employer's benefits department, or my other insurance company for the sole purpose of obtaining payment for my medical care. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

AUTHORIZATION TO RELEASE INFORMATION-For Coordination of Care: I hereby authorize Rapid Orthopaedic Care to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating treatment. I understand that my medical information is confidential and that I have a chance to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician and any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter.

PAYMENT FOR MEDICAL SERVICES: All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with the billing office. Necessary forms will be completed to file for insurance carrier payments. I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles and balance of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment, I agree to call the billing office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the term of my insurance policy to be paid directly to Rapid Orthopaedic Care or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I direct Rapid Orthopaedic Care to bill, in the event of non-payment for whatever reasons in accordance with the benefits of my current insurance policy, I will pay immediately. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be required to pay your entire balance and any collection agency fees, up to 25% of the balance owed and/or all attorney fees and costs incurred to collect the unpaid debt, before being scheduled for any further appointments.

My signature below verifies that I have read and understand the *Consent to Treat* outlined above and that a copy of the policy is available to me upon my request.

Patient Signature Date Signed

NOTICE OF PRIVACY PRACTICES

This notice describes how Rapid Orthopaedic Care ("ROC") may use and disclose your medical information, and how you may access this information. Please review it carefully.

If you have any questions about this Notice, please contact us at (318) 300-3898, or by email at info@rocorthocare.com.

We are required by law to maintain the privacy of your Protected Health Information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

Changes to this Notice:

We reserve the right to change the terms of our Notice at any time. Any revisions of the Notice will be effective for all Protected Health Information that we maintain at that time. To receive a copy of the revised Notice, you may contact our clinic and request that a revised copy be sent to you in the mail or it is also available online at www.rocorthocare.com. Additionally, you may also obtain a copy in the Admissions Office at the time of your next appointment.

Commitment to Protecting Medical Information:

We understand and appreciate the personal nature of any information related to you and your health. ROC is committed to protecting your medical information, and are required by law to:

- Ensure the privacy of your identifiable medical information;
- Provide you with this notice of our legal duties and privacy practices with respect to your medical information; and
- Follow the terms of the most current Notice.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information.

"Protected Health Information" refers to 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.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by ROC to sign a consent form. Once you have consented to use and disclosure of your Protected Health Information for treatment, payment and health care operations by signing the consent form, ROC will use or disclose your Protected Health Information as described in this Section.

Each category of uses and disclosures will be explained but not every use or disclosure in each category will be listed. However, every permissible use or disclosure will fall under one of the following categories.

Treatment: We 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. We may disclose your Protected Health Information, as necessary, to doctors, nurses, counselors, physician assistants, nurse practitioners, or any other personnel involved in your care. 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, we may disclose your Protected Health Information to another physician or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your Protected Health Information will be used and disclosed, as needed, to obtain payment for your healthcare services. This may include uses and disclosures by and to the Health Information Management Department and our Business Office. Other uses and disclosures may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant Protected Health Information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your Protected Health Information in order to support ROC's operations and business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, conducting or arranging for other business activities and compliance with state law.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment. We will share your Protected Health Information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your Protected Health Information, we will obtain a written contract that contains terms that will protect the privacy of your Protected Health Information.

We 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. We may also use and disclose your Protected Health Information for other marketing activities. For example, your name and address may be used to send you a newsletter about our system and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes, for most marketing purposes or if we seek to sell your information. You may revoke your authorization by submitting a written notice addressed to the Practice Manager at 1549 E 70th Street, Suite 300 Shreveport, LA 71105. The revocation will not be effective to the extent ROC has already taken action in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your Protected Health Information in the following instances. You will be granted the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are not present or able to agree or object to the use or disclosure of the Protected Health Information, then in our best professional judgment, ROC may determine whether the disclosure is in your best interest. In this case, only the minimum necessary Protected Health Information relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you instruct us otherwise, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose Protected Health Information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your Protected Health Information in an emergency treatment situation. If this happens, ROC staff shall attempt to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or any ROC staff member is required by law to treat you and has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your Protected Health Information to treat you.

Communication Barriers: We may use and disclose your Protected Health Information if we attempt to obtain consent from you but are unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your Protected Health Information in the following situations without your consent or authorization. These situations include, but are not limited to, the following:

Required By Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the minimum necessary. You will be notified, as required by law, of any such uses or disclosures. We may use or disclose your information to state agencies for registry purposes as appropriate and required under State of Louisiana law, for example, vital statistics, tumor, burn or trauma registries.

Public Health: We may disclose the minimum necessary amount of your Protected Health Information for public health activities to a public health authority that is permitted by law to collect or receive the information. These uses and disclosures may include, but are not limited to, the following:

- To prevent or control disease, injury, or disability;
- To report child abuse or neglect by making a telephone report to the appropriate authorities, and to follow this report with a written confirmation;
- To report reaction to medication or problems with products as required by the Food and Drug Administration;

- 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; or
- To notify the appropriate government authority if we believe a client has been the victim of domestic violence. We will only make this disclosure if you agree, and when consistent with the requirements or authorizations of applicable Louisiana and federal law.

Health Oversight: We may disclose Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings: We may disclose Protected Health Information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes. We may release the minimum necessary information if asked to do so by a law enforcement official:

- In response to a proper court order or similar process;
- In response to a subpoena for a staff member of ROC;
- About criminal conduct involving our facility;
- Suspicion that death has occurred as a result of criminal conduct;
- In the event that a crime occurs on the premises of our facility; or
- Medical emergency (not on ROC's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determination, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose Protected Health Information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected Health Information may be used and disclosed for organ, eye, or tissue donation purposes.

Research: We may disclose your Protected Health Information to researchers when an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information. In most cases, the medical information will be de-identified for privacy purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your Protected Health Information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual. Any such disclosure would be limited to the minimum necessary, and would be made to someone involved in the prevention of the threat.

Military Activity: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel (1) for activities deemed necessary by

appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

Workers' Compensation: We may disclose your Protected Health Information for workers' compensation and other similar legally established programs, in accordance with state and federal law regarding such disclosures.

National Security: We may disclose your Protected Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Required Uses and Disclosures: By law, we must make minimum necessary disclosures when required to do so by state, federal, or local law.

2. Your Rights Regarding your Protected Health Information

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 Copy: This means you may inspect and obtain a copy of Protected Health Information about you that is contained in a designated record set for as long as we maintain the Protected Health Information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, this generally does not apply to the following: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our clinic if you have questions about access to your medical record.

To inspect and/or copy your medical information maintained by ROC, you must submit your request in writing to the Health Information Management Systems Department. You may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with your request.

Right to Request an Amendment: If you feel any of your medical information maintained by ROC is incorrect or inaccurate, you may request an amendment of that information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

To request an amendment, your request must be made in writing and must include the reason for the request. All requests for amendment are to be submitted to the Health Information Management Department.

ROC reserves the right to deny your request for amendment for any of the following reasons:

- The information is complete and accurate;
- We did not create the information;
- The person or entity that created the information is no longer available to make the amendment;
- The information is not part of the medical information kept by our facility; or

- The request pertains to information that you are not permitted to inspect and copy.

You have the right to file a statement of disagreement with us. In turn, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our clinic if you have questions about amending your medical record.

Right to an Accounting of Disclosures: This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices for a time frame of up to six years from the date of the request. It excludes routine disclosures, such as any we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes.

To request an accounting of disclosures, you must submit a request in writing. Your request must state a time period, which may not exceed six years. You will not be charged for the first request for accounting within a twelve-month period; however, you may be charged a fee for the administrative costs of retrieving, copying, mailing, and any other activities associated with any additional requests for accounting. You will be notified of the costs involved and will have the option to withdraw your request at that time, before any costs are incurred.

Right to Request Restriction: You have a right to request that ROC restrict the use or disclosure of any part of your Protected Health Information for the purposes of treatment, payment or health care operations. You may also request that your Protected Health Information be disclosed to family members or friends for notification purposes on an all or nothing basis. You must decide whether to grant disclosure to all family and friends, or to none.

You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays in full for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

Right to Request Confidential Communications: You have the right to request to receive confidential communications from ROC by alternative means or at an alternative location. For example, you may wish to be contacted only at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

This request must be made in writing and must specify how and where you wish to be contacted.

Right to obtain a copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices upon request. To receive a copy of this Notice, or any future revisions of the Notice, you may contact our office and request that a revised copy be sent to you in the mail or it is available online at www.rocorthocare.com. Additionally, you may also obtain a copy from the front desk reception at the time of your next appointment.

3. Complaints

If you believe your privacy rights have been violated, you may file a complaint with ROC or with the Secretary of Health and Human Services. You may also call the office at (318) 300-3898 to file a complaint by speaking with the Practice Manager, or contact the clinic for further information about the complaint process. We will not retaliate against you for filing a complaint.

If you have any questions about this Notice, please contact our clinic at (318) 300-3898, or by email at info@rocorthocare.com.

This Notice was published and becomes effective on **August 15, 2022.**