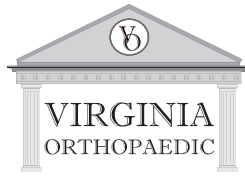


Preston A. Waldrop, MD
Sports Medicine & General Orthopaedist, ABOS, AAOS

Mark L. Hagy, MD
Foot, Ankle, Knee Specialist & General Orthopaedist, ABOS, AAOS, AAFAOS

R. Michael Wilson, PA-C, AAPA, VAP



Gregory D. Riebel, MD
Minimally Invasive Spine Specialist & General Orthopaedist, ABOS, AAOS

William E. Hooper, MD
Hand Specialist & General Orthopaedist, ABOS, AAOS

Lynn S. Gilbert, PA-C, AAPA, VAPA

Date _____

PLEASE PRINT

Home Phone _____

Patient Information

Name _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

Primary Insurance

Person responsible for account _____

Last Name First Name Initial

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber name _____ Relation to patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to **Virginia Orthopaedic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

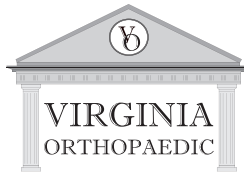
Responsible Party Signature _____ Relationship _____ Date _____

Virginia Orthopaedic P.C. • 101 Knotbreak Road • Salem, VA 24153 • Phone (540) 444-4020 • Fax (540) 444-4021

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AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS

LIFETIME FORM

PATIENT'S NAME: _____

SUBSCRIBER'S NAME: _____

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Virginia Orthopaedic P.C., for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and/or their insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services.

SUBSCRIBER'S SIGNATURE: _____

DATE: _____

I AUTHORIZE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO MY REFERRING PHYSICIAN.

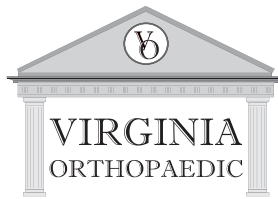
(Signature)

(Date)

I AUTHORIZE THE RELEASE OF COMPLETE MEDICAL INFORMATION TO ANY PHYSICIAN OR OTHER HEALTH CARE PROVIDER TO WHOM I AM REFERRED BY MY PHYSICIAN.

(Signature)

(Date)



Name: _____ Age _____ Birthdate: ___ / ___ / ___
Occupation: _____ Are you disabled: yes / no / partial (circle one)
Work time lost to back trouble last year: _____
Primary Care Doctor: _____ Referred by: _____

When did your present pain start? _____
Please describe the events of your initial injury: _____

Do you have trouble getting to sleep? ___yes, ___no
Does the pain awaken you? ___yes, ___no
Have you recently lost weight? ___yes, ___no
Is your appetite ___good, ___poor
Have you any bladder or bowel changes? ___yes, ___no
Do you have any pain with coughing or sneezing? ___yes, ___no
Is your pain: ___improving ___the same ___worsening
What is your best position? _____
What is your worst position? _____
When you awake is your pain: ___improved, ___worse, ___the same
As the day progresses is your pain: ___improved, ___worse, ___the same
How far can you walk? _____blocks or _____miles
Please list any prior back, leg, neck, or arm problems: _____

Which of the following treatments have you had?			If so did it help?	
Pain medication	___Yes	___No	___Yes	___No
Antiinflammatories	___Yes	___No	___Yes	___No
Injections	___Yes	___No	___Yes	___No
Brace	___Yes	___No	___Yes	___No
Physical therapy	___Yes	___No	___Yes	___No
Bedrest	___Yes	___No	___Yes	___No
Chiropractic	___Yes	___No	___Yes	___No

Please list all medical problems _____

List all your medications: _____
_____ (use other side if you need more room)

List any medication allergies: _____
List all surgeries you have had including spine surgery (with dates): _____

Have you ever had anesthetic complications? ___no, ___yes (list) _____

Do you have a family history of the following: __scoliosis, __diabetes, __arthritis,
__cancer, __heart disease, __back trouble

Do you have poor circulation? __, blood clots, __phlebitis, __heart murmur, __fevers

Do you feel that something has gone terribly wrong with your body? __yes, __no

Do you have urinary problems: __# times at night, __trouble beginning

Do you have: __ulcers, __pancreatitis, __hepatitis, __vomiting, __Prostate trouble
__difficulty sleeping, __weakness, __loss of balance, __depression

Do you smoke? __yes, __no __packs per day

Do you drink alcoholic beverages? __yes, __no __# drinks per day

Your height __ __

Your weight _____

Please rate your usual pain from 1 to 10 (with 10= incredible pain)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (please circle a number)

Using symbols please mark the affected areas on the drawing below:

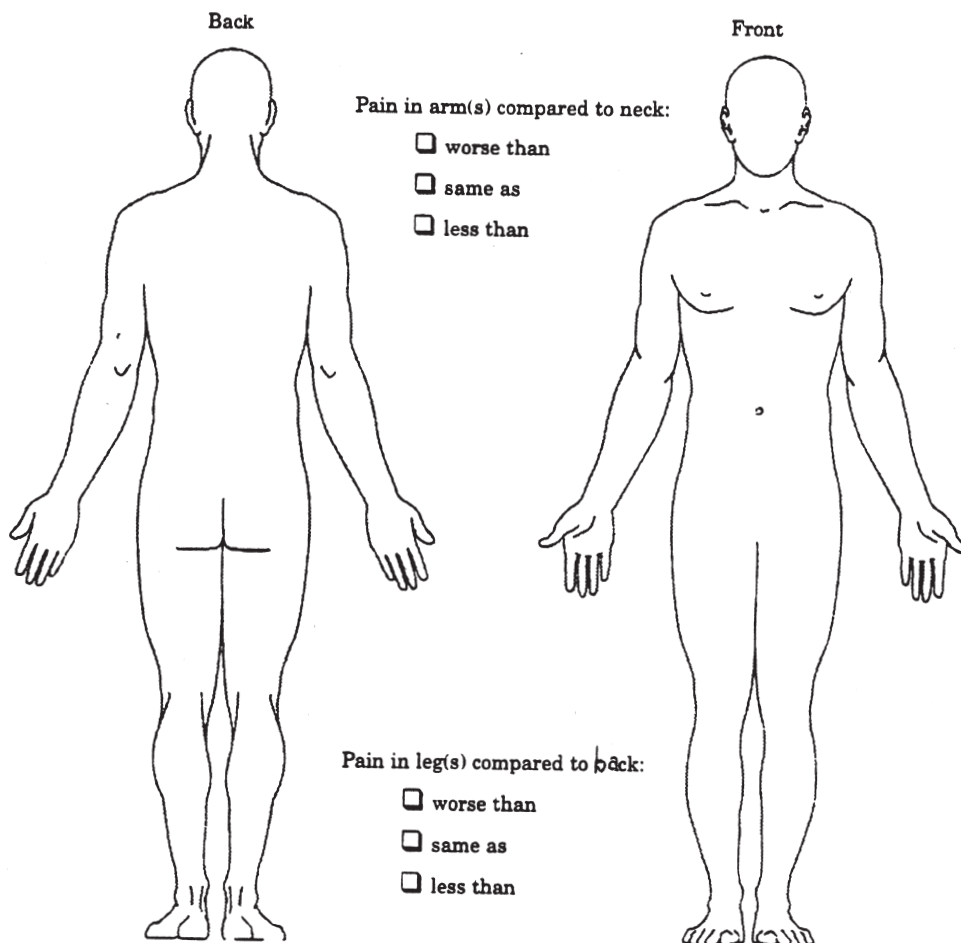
Numbness o o o

Pins and needles - - -

Burning x x x

Stabbing / / /

Ache v v v



<< Please do not write on this page >>

Musculoskeletal: Gait / station
scoliosis (R^, L^)
inspection / palpation (crepitation, asymetry, masses)

balance <- _____ -> (cm)

kyphosis

Range of Motion: { F / E }
Rotation { R / L }
side bending { R / L }

Hip or shoulder (ROM)

impingement _____ SS Stress _____ apprehension _____
Muscle tone, atrophy [] abnormal motions

	Strength R / L	Reflex R / L		Strength R / L	Reflex R / L
Deltoid	/		Psoas	/	
Biceps	/	/	Quads	/	/
Triceps	/	/	Hams	/	
Braciorad	/	/	TA	/	
Wrist ext	/	/	EHL	/	
Wrist flex	/	/	Inverters	/	
Grip	/		Everters	/	
Intrinsics	/		GS	/	/

Nerve tension _____ spurling _____ SLR _____ bowst _____
Neurologic; affect coordination
[] babinski, [] spurling, [] clonus,

sensation
rash
tenderness
swelling
scar

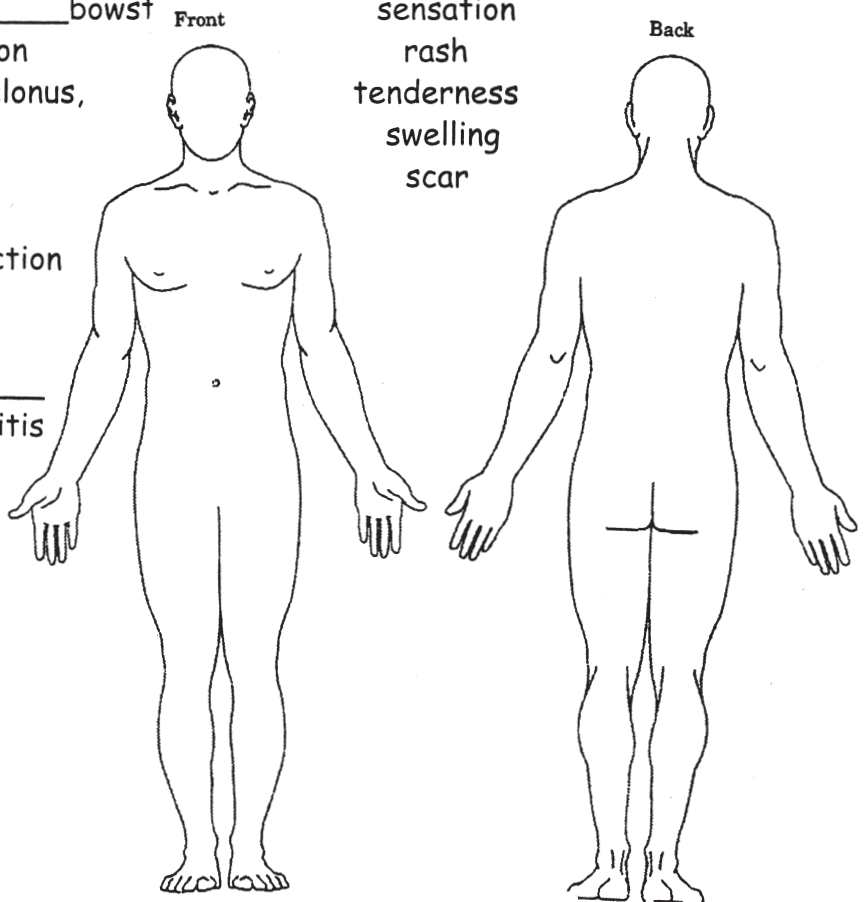
Waddell's: __tenderness, __simulation,
__distraction, __regional, __ov action

Cardiovascular: [] edema
pulses DP _____ RAD PT _____
Lymphatic: [] lymph nodes [] lymphangiitis

Studies:

Impression:

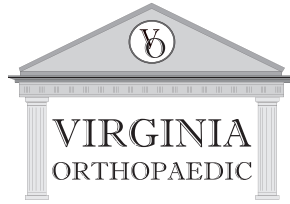
Plan:



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It is the policy of Virginia Orthopaedic and Dr. Gregory D. Riebel that all patients will be evaluated at their visit to see what the best treatment options are. Dr. Riebel is a spine surgeon, not a pain management specialist. If you feel that pain medication is the only option for you, then you should speak with your primary physician regarding an appointment with a pain management doctor and cancel your visit with Dr. Riebel. If you are currently taking Pain Medication you will need to continue getting that from your prescribing physician.

Thank you,
Virginia Orthopaedic

Patient Signature

Date

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a 'Notice of Privacy Practice' statement.

VIRGINIA ORTHOPAEDIC, PC NOTICE OF PRIVACY PRACTICES

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.

Virginia Orthopaedic, PC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Virginia Orthopaedic, PC."

"It is our policy to provide a substitute health care provider, authorized by Virginia Orthopaedic, PC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Virginia Orthopaedic, PC for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below: (example) *“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”*

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Comeau Health Care Associates sponsored fund-raising events.”

Change of Ownership.

In the event that Virginia Orthopaedic, PC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that [Practice Name] is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.
- You have a right to request that Virginia Orthopaedic, PC amend your protected health information. Please be advised, however, that Virginia Orthopaedic, PC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Virginia Orthopaedic, PC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Virginia Orthopaedic, PC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Virginia Orthopaedic, PC is required by law to comply with this Notice.

Virginia Orthopaedic, PC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Administrative or Clinical Team Leader by calling this office at 540-444-4020. If either Team Leader is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Virginia Orthopaedic, PC has handled your health information should be directed to Administrative or Clinical Team Leader by calling this office at 540-444-4020. If either Team Leader is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
 200 Independence Avenue, S.W.
 Room 509F HHH Building
 Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Virginia Orthopaedic, PC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

 Patient's Name (print)

 Patient's Signature Date