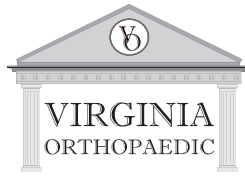


Preston A. Waldrop, MD
Sports Medicine & General Orthopaedist, ABOS, AAOS

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

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



Gregory D. Riebel, MD
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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.

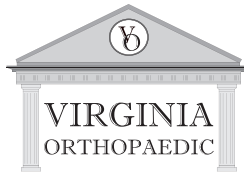
Responsible Party Signature _____ Relationship _____ Date _____

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.

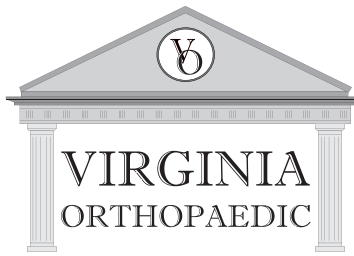
(Signature)

(Date)

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New Patient Intake Information

Date: _____

Name: _____ Age: _____

Primary Care Doctor: _____

Reason for today's visit: _____

How Problem Started: _____

Date of injury (if any): _____ Is this problem work related? _____

MEDICAL ALLERGIES: _____

CURRENT MEDICATIONS: _____

Past Medical History:

Heart Disease	Y	N	Diabetes	Y	N	Height	_____
Heart Attack	Y	N	Blood Pressure	Y	N	Weight	_____
Irregular Beat	Y	N	Asthma	Y	N		
Heart Failure	Y	N	Lung Problems	Y	N		
Stroke	Y	N	Seizures	Y	N		
			Stomach Ulcers	Y	N		
Cancer	Y	N	If yes, what kind?	_____			

What treatment have you had to date? (circle) Injection Surgery Medication Brace

Past surgical history: _____

Are you disabled? _____ Yes _____ No If yes, from _____ to _____

Family Medical History: (significant medical problems)

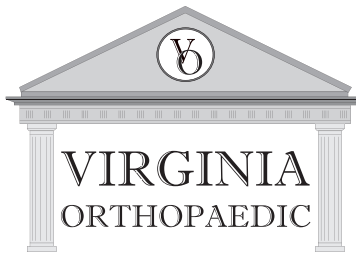
Father: _____ Mother: _____

Brother/Sister: _____ Grandparents: _____

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New Patient Intake Information

Social History:

Employer/Type of Work: _____

Married Y N

Smoke Y N How Much? _____

Alcohol Y N Circle: Rarely Occasionally Frequently

Review of Systems (*circle if applicable*):

General: fever chills night sweats weight loss loss of appetite

Skin: rashes bruising discoloration

Head: headaches dizziness seizures stroke

Eyes: visual changes loss of vision

Ears: ringing in ears vertigo hearing loss

Mouth/Throat: dental disease hoarseness throat pain

Respiratory: cough shortness of breath wheezing other

Cardiovascular: chest pain swelling in ankles dizziness valve disease

Gastrointestinal: difficulty swallowing nausea vomiting bowel changes

Urinary: frequency hesitancy pain with urination blood in urine

Endocrine: excessive thirst skin or hair changes cold intolerance

Musculoskeletal: joint pain joint swelling arthritis muscle pain

Where? _____

Neurological: memory loss depression weakness numbness

I certify that the above information is correct to the best of my knowledge.

Signature: _____

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