PATIENT INFORMATION

Primary Contact Number ______________ Is it OK to text message? ☐ YES ☐ NO

Secondary Contact Number ______________ Is it OK to text message? ☐ YES ☐ NO

Date ________ E-mail ______________ Work Number ______________

Patient ______________ (Last Name / First Name / M.I) SS # ______________

Sex ☐ M ☐ F Age ______ Birthdate ______________ Driver's Lic. # ______________

Street Address ______________

City ______________ State ______________ Zip ______________

Patient Employed By ______________ Occupation ______________

Business Address ______________

Primary Care Doctor ______________ City ______________ Phone ______________

Who referred you to our practice? ______________

Do you have Medical Insurance? No Yes If yes, name of subscriber: ______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Primary Language ______________ Race ______________

Spouse's Name ______________ Birthdate ______________ SS # ______________

Spouse's Employer ______________ Work Phone ______________

Is the patient a minor, student, or insured under parent? No Yes

If yes, please provide the following:

Mother's Name ______________ Birthdate ______________ SS # ______________

Street Address ______________ Home Phone ______________

Mother's Employer ______________ Work Phone ______________

Father's Name ______________ Birthdate ______________ SS # ______________

Street Address ______________ Home Phone ______________

Father's Employer ______________ Work Phone ______________

Emergency Contact: ______________ Phone ______________

AUTHORIZATION TO PAY PHYSICIAN/ ASSIGNMENT OF BENEFITS

I, the undersigned, have insurance coverage with ______________ Insurance Company(ies) and assign directly to Center for Orthopaedic Specialists all medical and surgical 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 release of all information necessary to secure payment benefits. I authorize use of this signature on all my insurance submissions.

Signature: ______________ Date: ______________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Center for Orthopaedic Specialists for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________ Date: ______________

Beneficiary Signature

HEALTH QUESTIONNAIRE

DATE COMPLETED:______________

NAME_________________________________ MARITAL STATUS: S / M / D / W AGE_____ SEX: M / F

OCCUPATION_______________________________ EMPLOYER________________________________

HEIGHT__________ WEIGHT__________ BIRTHDATE______________ DOMINANT HAND: L / R

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN):__________________________

SPORTS & HOBBIES:____

DRUG ALLERGIES: ☐ **NONE** OR LIST:____

VACCINATIONS: FLU VACCINATION ☐ YES ☐ NO PNEUMONIA VACCINATION (IF AGE 50+) ☐ YES ☐ NO

TOBACCO: ☐ NEVER SMOKED ☐ FORMER SMOKER ☐ CURRENT SMOKER ☐ YES, # OF PACKS PER DAY _____

ALCOHOL: ☐ NONE ☐ RECOVERING ALCOHOLIC ☐ YES, # OF DRINKS PER WEEK ______ / PER MONTH ______

SUBSTANCE/DRUG ABUSE: ☐ YES ☐ NO ☐ PRIOR HISTORY

MILITARY SERVICE: ☐ YES ☐ NO IF YES, WERE YOU INJURED DURING YOUR SERVICE: ☐ YES ☐ NO

PAST SURGERIES: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

____

____

ILLNESSES: ☐ **NONE** – OR LIST:

____

____

INJURIES/HOSPITALIZATIONS: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

____

____

FAMILY HISTORY: IF ANY OF THE FOLLOWING HAVE RUN IN YOUR FAMILY, PLEASE CHECK:

FATHER: YOB______ ☐ LIVING ☐ DECEASED ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ STROKE ☐ CANCER ☐ UNKNOWN

MOTHER: YOB______ ☐ LIVING ☐ DECEASED ☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ STROKE ☐ CANCER ☐ UNKNOWN

SYSTEM REVIEW: PLEASE CHECK IF YOU HAVE/HAD ANY OF THESE CONDITIONS:

GENERAL:	☐ **HEALTHY** ☐ ILL ☐ RECENT WEIGHT GAIN ______ LBS., LOSS ______ LBS. ☐ PREGNANT
HEART:	☐ **NORMAL** ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK ☐ ANGINA ☐ HEART FAILURE ☐ ARRHYTHMIA ☐ CORONARY ARTERY DISEASE
VASCULAR:	☐ **NORMAL** ☐ POOR CIRCULATION ☐ VARICOSE VEINS ☐ PHLEBITIS ☐ CAROTID ARTERY DISEASE ☐ LEG SWELLING / EDEMA ☐ HIGH CHOLESTEROL
LUNGS:	☐ **NORMAL** ☐ ASTHMA ☐ CHRONIC LUNG DISEASE ☐ BLOOD CLOTS IN LUNG ☐ PNEUMONIA
GASTROINTESTINAL:	☐ **NORMAL** ☐ HEARTBURN / REFLUX ☐ PEPTIC ULCER ☐ LIVER DISEASE ☐ OTHER:______________________________
URINARY TRACT:	☐ **NORMAL** ☐ BLADDER INFECTION ☐ PROSTATE ENLARGMENT ☐ FREQUENT URINATION ☐ KIDNEY STONES ☐ KIDNEY FAILURE
ENDOCRINE:	☐ **NORMAL** ☐ DIABETES ☐ THYROID ABNORMALITY ☐ OTHER:______________________________
HEMATOLOGIC:	☐ **NORMAL** ☐ BLOOD CLOTS ☐ ABNORMAL BLEEDING TENDENCIES ☐ BLOOD TRANSFUSION – (☐ YOUR OWN BLOOD, OR ☐ DONOR BLOOD)
NEUROLOGIC:	☐ **NORMAL** ☐ STROKE ☐ SEIZURES ☐ M.S. ☐ DEPRESSION
MUSCLES & JOINTS:	☐ **NORMAL** ☐ OSTEOARTHRITIS ☐ GOUT ☐ FIBROMYALGIA ☐ RHEUMATOID ARTHRITIS ☐ OTHER:______________________

HEAD & NECK:	☐**NORMAL** ☐VISUAL LOSS ☐SINUS PROBLEMS ☐HEARING LOSS ☐HEADACHE ☐OTHER:____
SKIN:	☐**NORMAL** ☐CANCER ☐PSORIASIS ☐ECZEMA ☐RASHES
INFECTIOUS DISEASE:	☐**NORMAL** ☐HEPATITIS A / B / C ☐HIV ☐TUBERCULOSIS
CANCER:	☐**NONE** ☐YES, TYPE:____
BONES:	☐**NORMAL** ☐OSTEOPENIA ☐OSTEOPOROSIS ☐FRACTURES, IF YES, WHICH BONES? ____

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR. WHEN DID THE PROBLEM BEGIN?

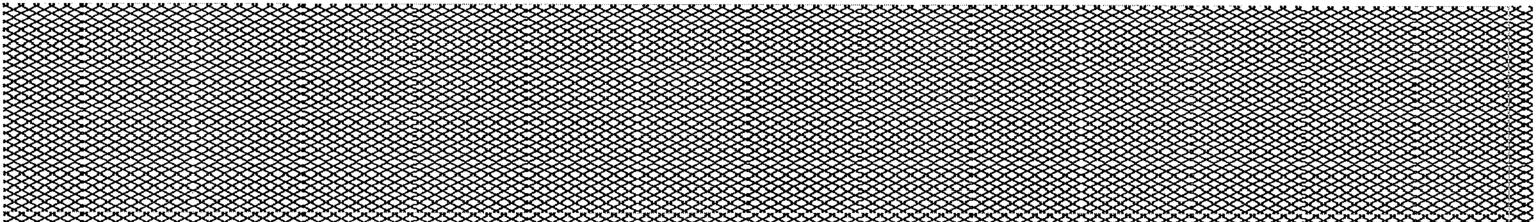
SCALE OF PAIN, TODAY: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(Circle One #) NO PAIN MODERATE WORST PAIN POSSIBLE

PLEASE USE THE REMAINDER OF THIS PAGE TO LIST YOUR CURRENT MEDICATIONS
(Please include over the counter, vitamins/supplements)

Medication(s):		Reason for use of the Medication(s):	
1)____	6)____	1)____	6)____
2)____	7)____	2)____	7)____
3)____	8)____	3)____	8)____
4)____	9)____	4)____	9)____
5)____	10)____	5)____	10)____

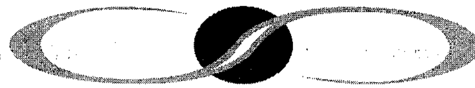
Pharmacy Name:____ City/Zip Code:____

DO NOT WRITE BELOW THIS LINE



7301 Medical Ctr Dr
Suite 400
West Hills, CA 91307
t:818-264-3344
f:818-264-3433

1220 La Venta Dr
Suite 202
Westlake Village, CA 91307
t:805-449-0066
f:805-449-0016



Center for Orthopaedic Specialists

11550 Indian Hills Rd
Suite 300
Mission Hills, CA 91345
t:818-403-6337
f:818-403-6339

18133 Ventura Blvd
Suite 302
Tarzana, CA 91356
t:818-466-7770
f:818-466-7777

Robert H. Fields, M.D. • Evan J. Bachner, M.D.• Kevin A. Nadel, M.D. • Andrew Rah, M.D. • James M. Fox, M.D. • Nirav J. Shah, M.D.
Purab C. Viswanath, M.D. • Aneet S. Toor, M.D. • Sumit H. Rana, M.D. • Ashkhan Kaviani, P.A.C.

Dear Patient,

We are pleased that you have chosen us as your physicians and we would like to welcome you to our office. Our goal is to provide you with the best medical care possible. Please fill the attached so that the doctor will have all of the necessary information to treat you. We would like to take this opportunity to acquaint you with our business office policies and we will be happy to answer any questions you may have.

- **Copayments are collected at the time of service and are not billable.**
- **We will bill you for any balance of your responsibility after we receive the explanation of benefits from your insurance company. Your patient balance will begin to accrue finance charges at the rate of 1 ½% per month (18% per year) from the 30th day after your bill is issued.**
- **Services are not rendered on a "lien" basis (deferral of payment pending the settlement of legal cases). Services are not rendered on a third party basis, meaning that we cannot bill another party's auto insurance medical pay.**

Our staff will be happy to bill your insurance for plans which we are participating providers. It is imperative that you inform us of any changes you make in your insurance coverage, such as switching to a different insurance company, policy number or a different plan within the same company (For example, if you switch from Blue Cross Prudent Buyer to Blue Cross California Care). Please inform us of changes prior to scheduling your appointment or you may become personally liable for the charges since we do not belong to all insurances plans.

I am receiving medical services based on these financial policies as indicated above. All services from the date below will be handled as follows (check one):

_______ I have health insurance and will assign my benefits. I will pay all copayments as indicated above and will pay all charges not covered by my insurance.

_______ I have no insurance and will pay for services at the time they are rendered.

Date: ______________________ **Signature:** ____

CREDIT CARD AUTHORIZATION **(Optional)**

Date: _____________________

For your convenience we accept credit card payments. You may complete this form to authorize Center for Orthopaedic Specialists to charge your credit card once we have received your insurance companies payment for services.

I authorize Center for Orthopaedic Specialists to charge this credit card for balance due after insurance has processed – Visa- MasterCard

Name: ____________________________________ Card #:___________________________________

Signature:__________________________________ Exp Date:______________________

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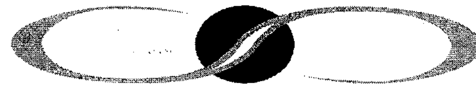
f:805-449-0016



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CONSENT TO RELEASE

VERBAL OR WRITTEN INFORMATION

The State of California mandates that medical information may be shared only with the patient, or the patient's legal representative. In accordance with this law, every employee of **Center for Orthopaedic Specialists** is required to sign a Confidentiality Statement on an annual basis, indicating they will keep the medical information for every patient in the strictest confidence.

Adhering to the Confidentiality Policy is difficult when family members (spouses, children, and siblings) inquire about a patient's medical care. The staff and/or physicians cannot release medical information without permission from the patient or the patient's legal representative.

If you wish to give permission for staff and/or physicians to verbally release general medical information to family members, list the name(s) and relationship of those individuals in the space provided below.

General Medical Information excludes the discussion of Psychiatric Services; Drug and Alcohol; Counseling; Sexually Transmitted Diseases; HIV Testing; Pregnancy or Termination of Pregnancy.

Name	Date of Birth	Relationship

If you DO NOT wish to give permission for general medical information to be release verbally to family members, check here ☐ and sign below.

I authorize that the above individual(s) may have access to information regarding my general medical condition. I will notify **Center for Orthopaedic Specialists** if I wish to add or delete individual who may have access to my medical information.

_______________________ Patient's Name (PRINT)

_______________________ Patient's Signature

_______________________ Date

_______________________ Witnessed By

NOTICE OF PRIVACY PRACTICES

Center for Orthopaedic Specialists

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11550 Indian Hills Rd. Suite 300 Mission Hills, CA 91345

Stacy Cowan – Practice Manager (818) 264-3344, Sandy Alvarado, Cathy Ramirez, Adriana Arredondo, Patricia Quintero, Christina Del Nostro, Sandra Arenales, Barbara Holland [Privacy Officers]

Effective Date: September 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We

may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. If you are currently an enrollee of a health plan, we may receive payment for communications to you in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or

management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of your covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any payment for other marketing communications without your prior written authorization unless you have a chronic and seriously debilitating or life-threatening condition and we are making the communication in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. If we make these types of communications to you while you have a chronic and seriously debilitating or life-threatening condition, we will tell you who is paying us, and we will also tell you how to stop these communications if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for any marketing activity you authorize.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult 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. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

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

15. Public Safety. We may, and are sometimes required by law, 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 the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited

circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. If your written request clearly, conspicuously and specifically asks us to send you or some other person or entity an electronic copy of your medical record, and we do not deny the request as discussed above, we will send a copy of the electronic health record as you requested, and will charge you no more than what it cost us to respond to your request.]

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website www.cos-orthopaedics.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized for filing a complaint.

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11550 Indian Hills Rd. Suite 300 Mission Hills, CA 91345

Stacy Cowan – Practice Manager (818) 264-3344 [Privacy Officer]

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, posted on our website www.cos-orthopaedics.com, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________________.

Signed: ______________________________ Date: ______________________________

Print Name: ___________________________ Telephone: ___________________________

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient.

Name and Address of Patient: ____

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