BONE & JOINT SURGEONS, INC.
Orthopedic Surgeons

Clark D. Adkins, M.D.
Jason A. Castle, M.D.
Carrie P. Gosselink, D.P.M.
Paul S. Legg, M.D.
Peter J. Lukowski, M.D.
John P. Pierson, M.D.
William G. Sale, III, M.D.

100 Tracy Way • Charleston, WV 25311 • 304-343-4583 • Fax 304-343-9207 • www.bonedoc.net

Dear Patient,

Welcome to Bone & Joint Surgeons, Inc. We look forward to helping you with your orthopedic needs. Enclosed is information you will need regarding our office policies. Please complete the patient information, medical information, past medical and surgical history forms and bring them with you to your scheduled appointment.

Please bring any current x-ray, CT scan, MRI films or other radiology disks. If you are currently wearing orthotics or any type of brace, please bring these to your appointment.

We encourage you to wear loose comfortable clothing and/or bring shorts on the day of your appointment to facilitate ease of examination. We also ask our patients to refrain from wearing perfume or cologne due to allergies of some of our other patients and as a courtesy to our staff.

If you need to cancel or reschedule your appointment please call our office at least 24 hours ahead so that your appointment time can be allocated to another patient who is seeking treatment.

Deductibles and co-payments are due at the time of service. Also please bring all insurance cards and billing information.

Thank you,
Bone & Joint Surgeons, Inc.

Appointment Date: _____ Time: _____ ☐ a.m. ☐ p.m.
Appointment with ☐ Dr. Adkins ☐ Dr. Gosselink ☐ Dr. Lukowski ☐ Dr. Sale
☐ Dr. Castle ☐ Dr. Legg ☐ Dr. Pierson

Directions to Bone & Joint Surgeons

Take **INTERSTATE 64 to EXIT #99 – Greenbrier Street.** Turn towards Yeager Airport and drive for approximately 1 mile. Turn left at the light onto **Deitrick Boulevard, NorthGate Business Park.** Stay in the left lane, turn right on **Tracy Way**, our office is on the left.

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Date___/_____/_____ I have an appointment with Dr. _____

Patient's Name_____ ☐ Male ☐ Female Date of Birth_____
(Last) (First) (MI)

Address_____ City_____ ST____ ZIP_____

Home Phone_____ Cell Phone_____ e-mail _____

SS#_____ Marital Status: M☐ S☐ W☐ D☐

Emergency Contact_____ Relationship_____ Home #_____ Cell #_____

Primary Care Physician_____ Date of last visit_____/_____/_____

Referring MD_____

Preferred Pharmacy_____ City_____

EMPLOYMENT INFORMATION

Employer: _____ ☐ Full time ☐Part time

Occupation_____ Work #_____ Student Y☐ N☐ ☐Full time ☐Part time

Spouse Name_____ Spouse Employer_____ Phone _____

MEDICAL INFORMATION

Reason for visit _____ Left ☐ Right☐ Bilateral ☐

When did symptoms start _____/_____/_____ If injury, Date of Injury _____/_____/_____

If an injury, how did injury occur? _____

Work related? Y☐ N☐ Accident Related? Y☐ N☐ Auto Accident? Y☐ N☐ Gradual onset Y☐ N☐ Sudden onset Y☐ N☐

Have you been treated by another physician for this problem? Y☐ N☐

If yes, please explain (Name of physician and date of treatment) _____

Have you ever been treated by another orthopedic / podiatric surgeon? Y☐ N☐

If yes, please explain (Name of physician and date of treatment) _____

MEDICAL INFORMATION

I consider my health ☐ Good ☐ Fair ☐ Poor

I have pain... constantly ☐ intermittently ☐ daily ☐ weekly ☐ rarely ☐

At best my pain is _____ out of 10 At worst _____ out of 10 (0 no pain ---10 worst pain you've ever had)

The pain is (check all that apply) dull ☐ sharp ☐ stabbing ☐ burning ☐ throbbing ☐ radiates down arm/leg ☐

Previous treatments: check all that apply. Please note those that did or didn't help.
Medications:

☐ Ibuprofen (Motrin, Advil)	Helped ☐ Didn't help ☐
☐ Aleve (Naprosyn)	Helped ☐ Didn't help ☐
☐ Tylenol	Helped ☐ Didn't help ☐
☐ Ultram (Tramadol)	Helped ☐ Didn't help ☐
☐ Narcotics (Lortab, Hydrocodone, Percocet, Oxycodone, Morphine)	Helped ☐ Didn't help ☐
☐ Lyrica	Helped ☐ Didn't help ☐
☐ Neurontin	Helped ☐ Didn't help ☐
☐ Other _____	Helped ☐ Didn't help ☐

Have you tried Physical Therapy? Y ☐ N ☐ How much? _____

Injections? Cortisone Y ☐ N ☐ Synvisc Y ☐ N ☐ Hyalgan Y ☐ N ☐ Platelet Rich Plasma Y ☐ N ☐

I have trouble with: (check all that apply)

☐ Sleeping	☐ Knee locking	☐ Squatting
☐ Reaching overhead	☐ Knee catching	☐ Standing
☐ Combing my hair	☐ Knee gives away	☐ Running
☐ Lifting objects	☐ Popping or grinding	☐ Swelling
☐ Putting on pants/socks/shoes	☐ Going up stairs	☐ Redness
☐ Getting in/out of car	☐ Going down stairs	☐ Doing housework
☐ Pivoting	☐ Driving	☐ Other _____

How far can you walk without assistance or having to stop for a break?

☐< 50 ft. ☐ 50-100 ft. ☐ 100-500 ft. ☐ 500-1000 ft. ☐ ½ mile ☐ 1 mile ☐ unlimited

I have or have had: (Please check/circle all that apply)

☐ High blood pressure	☐ Asthma/Emphysema/Black Lung	☐ Diabetes – Insulin ☐ Yes ☐ No
☐ Heart Attack	☐ Thyroid Disease	☐ Cancer – Where?_____
☐ Congestive Heart Failure	☐ Ulcer/Reflux	☐ Blood Clots? – Where?_____
☐ Anemia/Unusual Bleeding	☐ Hepatitis/Jaundice	☐ Drug Dependency
☐ Anxiety/Depression	☐ Kidney/Bladder/Prostate Disease	☐ Stroke/Seizures
		☐ Other_____

PAST MEDICAL AND SURGICAL HISTORY

Patient Name _____ **Height** _____ **Weight** _____

Medications (please include over the counter meds, supplements, vitamins) See list ☐

_____

_____

_____

_____

_____

_____

_____

Allergies (Please include reaction)

_____

_____

_____

Are you allergic to?: Latex Y ☐ N ☐ Penicillin Y ☐ N ☐ Sulfa Y ☐ N ☐ Cortisone Y ☐ N ☐ Steroids Y ☐ N ☐

Chicken Y ☐ N ☐ Eggs Y ☐ N ☐

If yes, please list reaction: _____

Do you smoke? ☐ Yes ☐ No How much? _____ How long? ____ **Do you drink alcohol?** ☐ Yes ☐ No How much? _____

Previous surgeries (type & year):_____

_____

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No Any previous problems with anesthesia? ☐ Yes ☐ No

---

I have or recently have had: (Please check/circle all that apply)

☐ Fever/Chills	☐ Chest Pain	☐ Rectal Bleeding	☐ Skin Rashes/Skin Ulcers
☐ Cold/Flu symptoms	☐ Heart Irregularity	☐ Dark or Black Stool	☐ Recent Hair Loss
☐ Headaches	☐ Leg/Ankle Swelling	☐ Change in Bowel Habits	☐ Unplanned Weight Loss
☐ Blurred Vision	☐ Coughing Up Blood	☐ Burning with Urination	☐ Generalized Weakness
☐ Recent Vision Change	☐ Shortness of Breath	☐ Frequent Urination	☐ Depression
☐ Frequent Nose Bleeds	☐ Heartburn/Indigestion	☐ Menstrual Irregularity	☐ Loss of Appetite
☐ Hoarseness	☐ Nausea/Vomiting	☐ Vaginal Bleeding	☐ Other_____
☐ Hearing Loss	☐ Abdominal Pain		

Family History

Do you have a family history of: (Please check/circle all that apply)

☐ Heart disease ☐ Seizures ☐ Diabetes ☐ Stroke ☐ Kidney disease ☐ Thyroid disorder ☐ Cancer, what type_____

INSURANCE INFORMATION

Primary Insurance Company _____

Insured's Employer_____Phone #_____

Insured's Name _____

Insured's Birth date_____ Insured's SS# _____

Policy ID # _____ Group Name/Number _____

Secondary Insurance Company _____

Insured's Name _____

Insured's Birth date_____ Insured's SS# _____

Policy ID # _____ Group Name/Number _____

Date of Injury _____/_____/_____ Accident Related? Y ☐ N ☐

Is the injury work related? Y ☐ N ☐ If yes, has the injury been reported to the employer? Y ☐ N ☐

Is the injury due to an auto accident? Y ☐ N ☐ If yes, please complete the following

Name of Auto Insurance _____

Insurance Agent _____ Phone # _____

Policy Holder's Name_____

Policy Holder's Birth date_____Policy Holder's SS# _____

Policy ID # _____ Group Name/Number _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts.

I authorize the release of any medical information necessary to process my claim.

Signature of Patient or Responsible Party _____

Date _____

Please check below:

Y ☐ N ☐ I have had the opportunity to review the Bone & Joint Surgeons policies.

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Bone and Joint Surgeons, Inc. Patient Responsibility Policy

Welcome to Bone and Joint Surgeons, Inc. We take great pride in providing the highest quality care to all of our patients and we firmly believe that a good patient/physician relationship is based upon understanding and open communication.

The policies and protocol provided below are designed to assist you in obtaining and understanding our services from the beginning of the physician/patient relationship.

We also recognize the need for a clear understanding between our patients and our physicians regarding financial arrangements for medical care. The following information is provided to you to avoid any potential misunderstanding concerning payment for our professional services.

1. **Proof of Insurance/Proof of Identity** – You are required to show proof of insurance and a government issued photo ID or drivers' license at each appointment.

2. **Changes in Insurance** – If there are any changes in your insurance, you are required to notify our office. If you fail to provide us with proper notification of change in insurance, you may be responsible for all services rendered.

3. **Co-Payment** – Most insurance plans require the insured to pay a co-payment for office visits and other specified services such as x-rays and injections. Accordingly, there may be more than one co-pay required for treatment we provide to you. Your insurance plan requires that we collect your co-pay at the time you are seen and, consequently, you will be expected to pay this co-pay, in full, on the day of your appointment. Please come to your appointment prepared to pay your co-pay. Failure to pay your co-pay at your appointment may result in Bone and Joint Surgeons rescheduling your appointment and may also result in a cancellation fee of $25.

4. **Unpaid Balance Responsibility** -We are pleased to provide the service of submitting claims for our patients; however, we remind you that you are ultimately responsible for payment of any services we provide. You are exempt from this policy if your primary insurance carrier is Medicare or Workers' Compensation. Even though we will file insurance on your behalf, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. Patients without proof of insurance will be considered self-pay patients and services must be paid in accordance with our payment policies, including initial $200.00 co-pay amount. Your failure to pay all unpaid balances may result in you and your immediate family members being discharged from our practice.

5. **Managed Care** – All managed care (i.e. HMO, PPO, POS) co-payment amounts are due at the time of appointment check-in. If your insurance plan requires a referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit or procedure without a referral authorization, your insurance plan may deem this as "out of network" or non-covered treatment and you will be responsible for all of our charges. By signing below, you acknowledge that it is your responsibility to be aware of what services are covered by insurance and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

6. **Self-Pay** – All self-pay patients are responsible for their balance and payment is expected within sixty (60) days following treatment. If you need special payment arrangements please notify the office. Self-pay patients will be charged an initial co-payment of $200.

7. **Payment Plans** – There are some instances in which Bone and Joint Surgeons, Inc. will provide the opportunity for patients to make payments over either three or six consecutive months depending on the patient balance. Please contact one of our billing representatives to discuss this matter.

8. **Medicare** – Bone and Joint Surgeons, Inc. is currently a participating provider with the Medicare program and accepts as payment the following: a) the patient Medicare allowable; b) your deductible; and/or c) 20% co-insurance. If you have supplemental insurance to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding.

9. **Children of Divorced Parents** – Responsibility for payment of patients who are minor children and/or whose parents are divorced rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Bone and Joint Surgeons, Inc.

10. **Medical Records** – Our office is authorized to release your medical records to the insurance of the insured for the purpose a) of payment of claims; b) utilization management; and c) quality assurance. There may be a minimal charge for providing your records to other entities.

11. **Radiographs (X-Rays)** – Our office has the ability to send Radiographs on disc or film to other facilities. A processing fee may be incurred for this service. If taking films to another physician's office, it is your responsibility to determine which media is required. Please note that Bone and Joint Surgeons charges a separate fee for radiographs.

12. **Missed Appointment Policy** – We ask that you show consideration to our practice and our other patients by notifying our office of any cancellation by 3 p.m. of the day preceding your appointment (or by 3 p.m. on Friday for a Monday appointment). This is to allow us time to offer your appointment time slot to another patient who needs our care. Given the volume of patients under

our care, we reserve the right to charge you a $25.00 patient no-show/late-cancellation fee if you do not show up for appointments or cancel appointments late. After-hour messages regarding cancellations may be left at (304) 343-4583. If you miss scheduled appointments, Bone and Joint Surgeons, Inc. reserves the right to discharge you from our care.

13. **Late Appointment Arrival Policy** – If you arrive for your appointment more than 30 minutes late, Bone and Joint Surgeons, Inc., will try to accommodate you depending upon the physician's schedule and the circumstances of your late arrival. However, your appointment will likely need to be rescheduled given the volume of patients under our care. If your late arrival results in us rescheduling your appointment, we reserve the right to charge you a late cancellation fee.

14. **Cancellation/Rescheduling Surgery** – We ask that you show consideration to our practice and our other patients by notifying our office at least 72 hours in advance if you are unable to keep your surgery appointment. We need to reserve the option to offer that surgery appointment to another patient who needs our care. If you have a schedule conflict, we will be happy to work with you in rescheduling a time more convenient. Failure to provide a 72-hour cancellation notice may result in your discharge from our practice.

15. **Charges for Forms** – Bone and Joint Surgeons, Inc. charges a $10.00 fee for processing disability forms including short-term disability, long-term disability, and the Family Medical Leave Act form requested by you or a third party. The fee must be paid prior to release of medical records or at the time the forms are picked up. We will gladly mail or otherwise provide forms to the requesting party at no additional charge.

16. **Guaranty of Payment** – The patient, responsible party or his/her legal guardian is fully responsible for payment of medical care for our services. Any payment not covered by insurance is the patient's immediate responsibility. Your signature below indicates your understanding of this policy

17. **Returned Check Charge** – We reserve the right to charge $30.00 for returned checks.

On the Day of Your Appointment

We encourage you to wear loose comfortable clothing and/or bring shorts on the day of your appointment to facilitate ease of examination. We also ask our patients to refrain from wearing perfumes or cologne due to allergies of some of our other patients and as a courtesy to our patients and staff.

Patient/Guardian Last Name, First Name _____, _____

Patient/Guardian Signature _____ Date _____

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EFFECTIVE DATE: 10/11/10

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

WHO WILL FOLLOW THIS NOTICE:

This notice describes the practice of Bone & Joint Surgeons, Inc., and that of:

- Any physician or health care professional authorized to enter or access information in your medical record
- All departments and units of this facility
- Any member of a volunteer group we allow to help you while you are receiving our services
- Participants in affiliated health care education programs
- All employees and associated health care personnel
- Any affiliate engaged in the provision of health care services on behalf of this facility

(In addition, these parties may share medical information with each other for health care services, payment or health care operations purposes described in this notice.)

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. To provide you with quality care and to comply with certain legal requirements, we create a record of the care and services you receive. This notice applied to all of the medical records of your care generated at or received by our facility.

WE ARE REQUIRED BY LAW TO:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. *Not every use or disclosure in a category will be listed.*

For Health Care Services. We may use medical information about you to provide you with medical health care services. We may disclose medical information about you to physicians, nurses, social workers, technicians, medical students, and/or students participating in health care education, or other health care personnel who are involved in taking care of you during your need for health care services. Our different departments also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. In order to coordinate and continue your care, we may also disclose medical information about you to external entities who may be involved in your medical care after you leave our facility.

For Payment. We may use and disclose medical information about you so that the health care services you receive from us may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about health care services you are going to receive to obtain prior approval or to differentiate whether your plan will cover the health care services.

For Health Care Operations. We may use and disclose medical information about you for health care operations. For example, we may use medical information to review our health care services and to evaluate the performance of our staff in caring for you. We may use and disclose medical information to contact you as a reminder that you have an appointment for health care services or medical care.

Business Associates. Some services, such as interpreting radiology or other tests, are contracted through external business associates. When this is necessary, we will require them to appropriately safeguard any information disclosed to them during the performance of their service.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about possible health care services, health-related benefits, or services that may be of interest to you.

Notification & Communication with Family. Using professional judgment, we may contact or assist in contacting a family member, personal representative, or other person responsible for your care, to advise them of your location and general condition. Depending on that person's involvement in your care or payment related to your care, additional information may be disclosed as deemed necessary.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law or in response to a valid subpoena.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations to handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

News Media. Sometimes, the circumstances that brought you to the facility are of interest to the media. All facilities use the terms: good, fair, serious or critical, to indicate a patient's condition without sharing specific medical information.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- Prevent or control disease, injury or disability;
- To report birth and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls or products they may be using;
- 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;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence;
- We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you as us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to Request Restriction. You have the right to request a restriction or limitation on the medical information we use or disclose about you for health care services, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. You could also ask to be excluded from surveys pertaining to patient satisfaction.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency health care services.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

WHO TO CONTACT

If you have questions or wish to inspect, amend or restrict your medical information, you may contact our Privacy Officer (304) 343-4583.

If you feel your privacy rights have been violated, you may contact our Privacy Officer at (304) 343-4583. You may also file a complaint with the secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice to our facility. The notice will contain on the first page, in the top right corner, the effective date. In addition, each time you register at or are admitted to our facility for health care services, as an inpatient or outpatient, we will offer you a copy of the current notice in effect. If you are being served by a home health agency, hospice, durable medical equipment or infusion company, you may request a copy of any changes to the current notice to be mailed to you.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not addressed by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Bone & Joint Surgeons, Inc. Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of my bills or in the performance of Bone & Joint Surgeons, Inc.'s health care operations and for other purposes that are permitted or required by law. It also describes my rights to access and control of my protected health information. The Notice of Privacy Practices is also posted in the waiting area of Bone & Joint Surgeons, Inc.

I understand that Bone & Joint Surgeons, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the Bone & Joint Surgeons, Inc. office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative/Date Patient's Social Security Number

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

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

☐ Home Telephone _____
(Note: I am authorizing you to leave a message with another person or answering machine at my home telephone number)

☐ Other Phone Number_____
(Note: I am authorizing you to leave a message with another person or answering machine at other numbers provided here)

☐ Work Telephone_____
☐ *OK to leave a message that indicates our office name, staff member and a call back number.*

☐ Written Communications: OK to send written communications to my home address.

Other Persons I authorize you to communicate with regarding my health information:
(Note: I must notify Bone & Joint Surgeons, Inc. in writing of any changes in this authorization)

Name(s)/Relationship:

1) _____ Phone # _____

2) _____ Phone #_____

3) _____Phone # _____

Signature of Patient/Personal Representative/Date