STEVEN N. BROURMAN, MD
TELEPHONE: (310) 657-2202
10700 Santa Monica Blvd #309, Los Angeles, CA 90025

NAME: ____________________ D.O.B. __________

ADDRESS:__________ CITY:__________ STATE:_____ ZIP:__________

PHONE: (_____) __________ SEX: (F)____ (M)____

S.S.# _____/______/_____ DRIVER'S LICENSE #:__________

INJURY OR ILLNESS

Part of the Body: ____________________
Date of Onset: _____/_____/_____

Referred By: ____________________ Phone:(____)__________
Emergency Contact: ____________________ Phone:(_____)__________

EMPLOYMENT INFORMATION

OCCUPATION:____________________
EMPLOYER: ____________________ PHONE: (____)__________

HEALTH INSURANCE (or copy of front & back of card)

INSURANCE:____________________ PHONE: (___)__________
ADDRESS: ____________________ CITY:__________ ____ZIP:__________
POLICY HOLDER: __________ D.O.B.__/__/_____ S.S.#__________
CERT#__________ GROUP#__________
SECONDARY INSURANCE:__________ PHONE: (___)__________
POLICY HOLDER: __________ D.O.B. ____ /_____/_____S.S.#__________
CERT#__________ GROUP#__________
Co-Pay: __________ Deductible: __________ Met: __________
Verified by: __________ Date: __________

I hereby authorize my Insurance Company to make payment directly to Sharp Imaging Medical Group, Inc. I realize that I am responsible for my deductible and any charges not paid by my Insurance Co. I authorize the release of any medical information necessary to process this claim. A photocopy of this authorization will be considered as valid as the original.

____
PATIENT'S SIGNATURE

_____/_____/_____
DATE

PATIENT QUESTIONNAIRE
Medical Information

DATE: ____/_____/_____

PATIENT NAME: ____

DATE OF INJURY OR ILLNESS: __________ PART OF THE BODY: ________________

DESCRIBE ONSET OF SYMPTOMS/OR INJURY:

____

____

____

CURRENT COMPLAINTS:

____

____

(Intensity): MINIMAL _____ SLIGHT _____ MODERATE _____ SEVERE: _____
(Frequency): INTERMITTENT_____ OCCASIONAL _____ FREQUENT_____ CONSTANT_____

DID YOU HAVE NUMBNESS? (YES OR NO) WHERE?

____

WHAT RELIEVES THE PAIN TO MAKE IT LESS OR WHAT MAKES IT MORE INTENSE OR FREQUENT?

____

____

DID YOU RECEIVE PREVIOUS MED. TREATMENT? WHAT TYPE? ________________

WHAT MEDICINE WERE YOU GIVEN? PHYSICAL THERAPY? DID IT HELP? ____________

____

____

WERE THERE ANY PREVIOUS ORTHOPEDIC INJURIES? ____________________

DO YOU HAVE EXISTING SYMPTOMS FROM A PRIOR PROBLEM? ________________

ALLERGIES: ____

MEDICATION: ____

OTHER COMMENT: ____

____

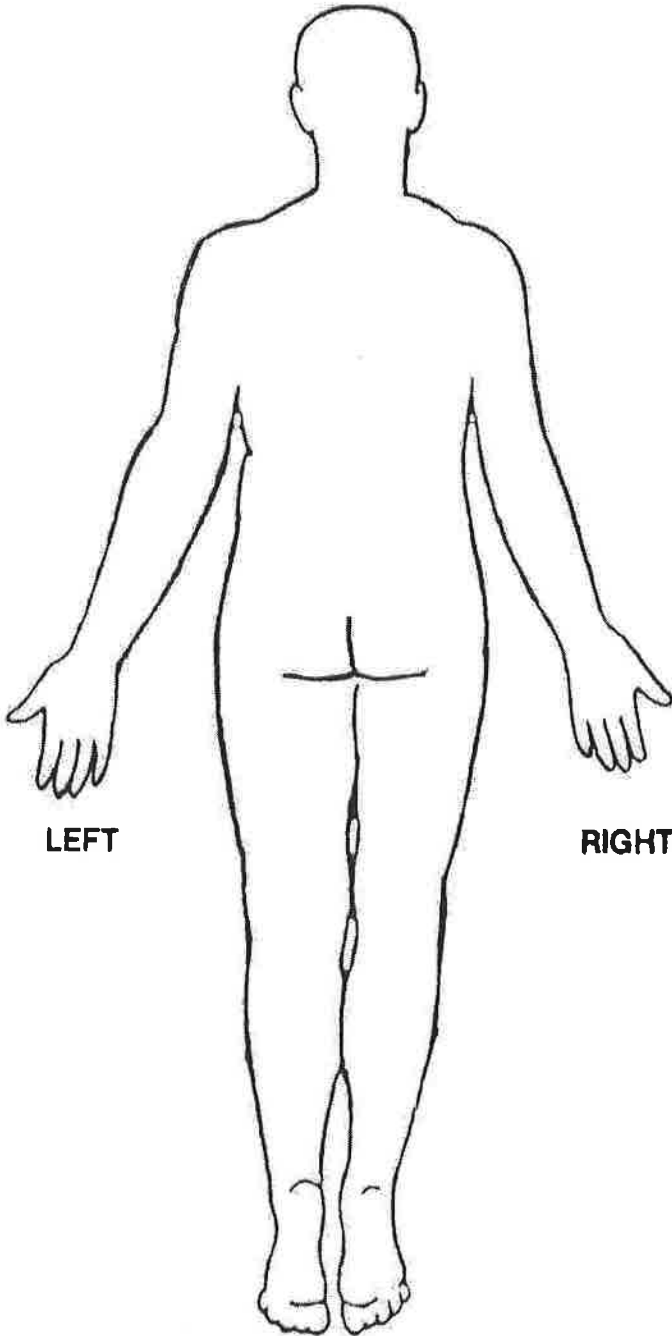
____

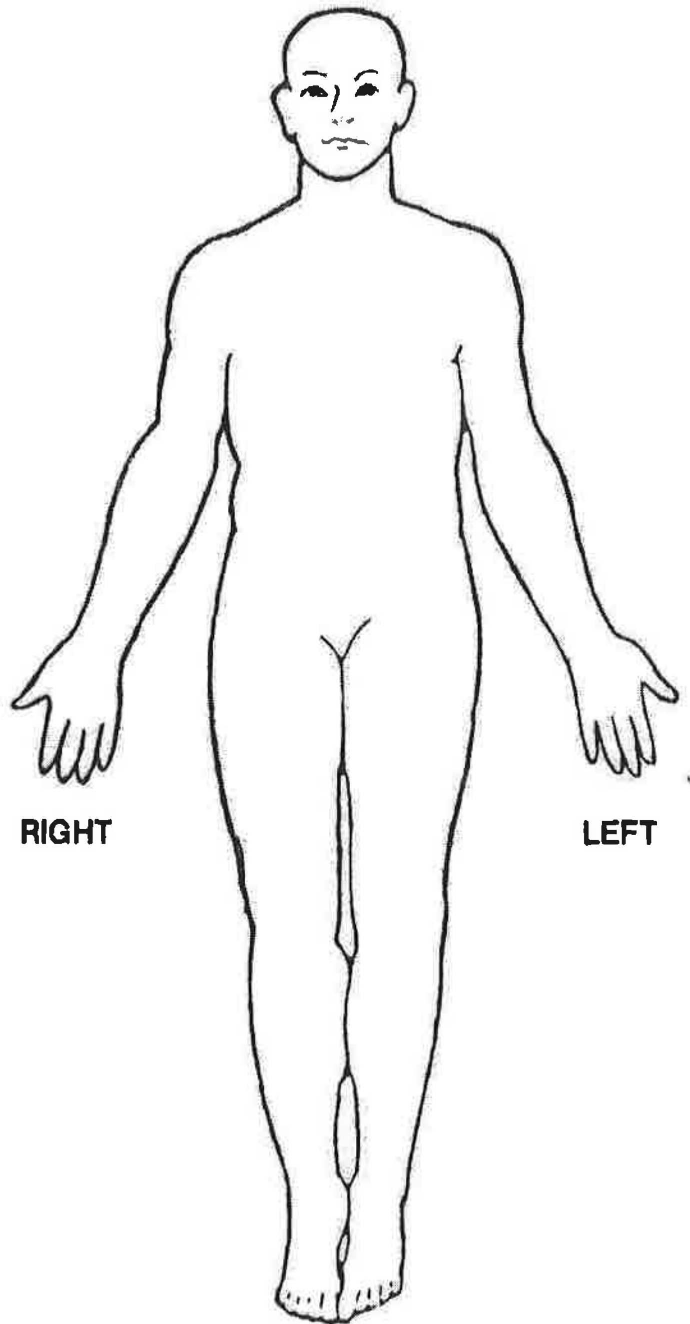
PAIN DRAWING

Name ____________________ Date ____________________

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning Pain	Stabbing Pain	Aching Pain
====	oooo	xxxxx	////	((((
====	oooo	xxxxx		
====	oooo	xxxxx	////	((((





ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about our patients. By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of this medical practice or clinic. We encourage you to read it in full and ask us any questions you may have.

I acknowledge that I have received the *Notice of Privacy Practices* of California Hand Surgery and Orthopedic Specialists Medical Clinic, Inc.

____________________________________ __________________________

Signature of Patient/Patient Representative Date

____

Print Name

For office use only.

WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

Please document your efforts to obtain acknowledgement and reason it was not obtained.

- ☐ Notice of Privacy Practices Given – Patient/Patient's Representative Unable to Sign
- ☐ Notice of Privacy Practices Given – Patient/Patient's Representative Declined to Sign
- ☐ Notice of Privacy Practices Mailed to Patient/Patient's Representative – Awaiting Signature
- ☐ Other Reason Patient/Patient's Representative did not sign ______________________

Please describe the good faith efforts made to obtain the individual's acknowledgement:

____________________________________ __________________________

Signature of Practice Representative Date

____

Print Name

NOTICE OF PRIVACY PRACTICES

OUR OBLIGATION TO YOU

We are committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. We must follow the terms of this Notice. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy too. **There are other laws that provide additional protections for medical information related to treatment for mental health, alcohol and other substance abuse, genetic information and communicable diseases, like HIV/AIDS. We will follow the requirements of these laws, too, when they apply to us.**

WE USE AND DISCLOSE INFORMATION:

For treatment For example, we give information to doctors, nurses, lab technicians, students, and others, such as results from tests you receive, and record that information for others to use for your treatment. We also share your health information with your other providers, such as your physical therapist or your hospital.

For payment For example, we may contact your insurer to verify what benefits you are eligible for, obtain prior authorization, and tell them about your treatment to make sure they will pay for your care. We will also use or disclose information to obtain payment from third parties that may be responsible for payment, such as family members, or to bill you. We may also share your health information with your other providers so that they can obtain payment for the services they provided you.

For healthcare operations For example, we give information to our staff to review quality of care, for performance improvement. We also use information for business planning. We may also remove certain identifiers (such as name) and use the information to study health care with other medical practices or clinics.

To individuals involved in your care or payment for your care such as friends or family, unless you ask us not to. We may disclose information to disaster relief organizations such as the Red Cross so they can contact your family.

For appointments and services to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services offered by us or your health plan.

With your written authorization *We may use or disclose medical information for purposes not described in this Notice only with your written authorization.* You may revoke any authorization at any time, in writing, but only as to future uses or disclosures, and only if we have not already acted in reliance.

As required by law but only to the extent and under the circumstances provided in such law.

To public health authorities for activities such as keeping birth or death records, preventing or controlling communicable disease, injury or disability, ensuring the

safety of drugs and medical devices, reporting child abuse, for workplace surveillance or work related illness and injury.

For health oversight activities to health oversight agencies for activities authorized by law, including audits, civil, administrative or criminal investigations, licensure or disciplinary actions, and monitoring of compliance with law.

Marketing Activities to use medical information about you to contact you in an effort to encourage you to purchase or use a product or service. If we receive any direct or indirect payment for making such a communication, however, we would need your prior written permission to contact you. The only exceptions for seeking such permission are when our communication (i) describes only a drug or medication that is currently being prescribed for you and our payment for the communication is reasonable in amount or (ii) is made by one of our business partners consistent with our written agreement with the business partner

In judicial proceedings in response to court or administrative orders; or subpoenas, discovery requests or other process after reasonable efforts to notify you or obtain a protective order.

To law enforcement to identify or locate suspects, fugitives or witnesses, or victims of crime (with your consent in some circumstances), to report deaths from crime, crimes on the premises, or, in emergencies, the commission of a crime.

To coroners, medical examiners, and funeral directors to identify a deceased person, determine cause of death, or as reasonably necessary to permit them to carry out their duties.

To organ donation organizations for organ procurement, eye or tissue transplantation or an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

For research purposes if a special board has reviewed the request for the information and approved a waiver of authorization under standards set by law to protect your rights to confidentiality. Otherwise, we will obtain your written consent before using your health information for research.

To prevent a serious threat to health or safety to the target of the threat, someone in a position to prevent it, or to law enforcement officials.

Military and veterans If you are in the armed forces, as required by command authorities.

***For national security**, intelligence activities, and protective services for the president* to officials as authorized by law to perform their duties and conduct investigations or make medical suitability determinations for Foreign Service.

To corrections facilities, as to inmates, for the health and safety of inmates and others.

For workers compensation or similar programs, as required by the applicable laws.

YOU HAVE THE FOLLOWING RIGHTS:

To exercise these rights see the contact information below

To Obtain a Copy of this Notice on request. You may contact our Privacy Officer.

To Request a Restriction on Certain Uses and Disclosures. We are not required to agree with your request, unless the disclosure is to a health plan for a payment or health care operation purpose and the medical information relates solely to a health care item or service for which we have been paid out-of-pocket in full. If we agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of Your Health Record, except in limited circumstances defined by federal regulations. A fee will be charged to copy your record. If you are denied access to your health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

If your medical information is maintained in an electronic health record, you may obtain an electronic copy of your medical information and, if you choose, instruct us to transmit such copy directly to an entity or person you designate in a clear, conspicuous and specific manner.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing **to Practice IQ** at **424-433-5704**.

An authorization form must be completed. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Our fee for providing you an electronic copy of your medical information will not exceed our labor costs in responding to your request for the electronic copy (or summary or explanation).

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the clinic will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

To Request an Amendment to Your Health Record. Your request must be in writing and give a reason. We may deny your request if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy or if the information is accurate and complete. Even if we accept your request, we do not delete any information already in your records.

To Request an Addendum to Your Health Record. You have the right to submit a 250 word letter (i.e., "addendum") to us about anything in your medical record

you disagree with and we will put this addendum in your medical record if you tell us to.

To an Accounting of Disclosures of Your Health Information for purposes other than disclosures incidental to permitted disclosures, and certain other disclosures excluded by regulation. You have the right to one free accounting every 12 months. We will charge you for additional accountings. Our fee for providing you an electronic copy of your medical information will not exceed our labor costs in responding to your request for the electronic copy (or summary or explanation).

To Request that we Contact you by Alternate Means (e.g. fax versus mail) or at alternate locations (specific address or phone number). Your request must be in writing, and we must honor it if it is reasonable.

Other Uses Of Medical Information

Other uses and disclosures of medical information not covered 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, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. 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.

To the extent required by law, when using or disclosing your medical information or when requesting your medical information from another covered entity, we will make reasonable efforts not to use, disclose or request more than a limited data set (as defined below) of your medical information or, if needed by us, no more than the minimum amount of medical information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

A limited data set means medical information that excludes the following items:

(i) Names;

(ii) Postal address information, other than town or city, State, and zip code;

(iii) Telephone numbers;

(iv) Fax numbers;

(v) Electronic mail addresses;

(vi) Social security numbers;

(vii) Medical record numbers;

(viii) Health plan beneficiary numbers;

(ix) Account numbers;

(x) Certificate/license numbers;

(xi) Vehicle identifiers and serial numbers, including license plate numbers;

(xii) Device identifiers and serial numbers;

(xiii) Web Universal Resource Locators (URLs);

(xiv) Internet Protocol (IP) address numbers;

(xv) Biometric identifiers, including finger and voice prints; and

(xvi) Full face photographic images and any comparable images.

QUESTIONS AND COMPLAINTS

To exercise any of the above rights, or if you have any questions, contact the Privacy Officer at **10700 Santa Monica Blvd #309, Los Angeles, CA 90025.** If you believe your privacy rights have been violated, you may file a complaint, in writing, with the Privacy Officer at the above address. ***There will be no retaliation against you for filing a complaint.*** You also have the right to complain to the Secretary of the Department of Health and Human Services at: Office for Civil Rights, 90 7th Street, Suite 4-100, San Francisco, California 94103, Attention: Privacy Complaints; Phone: (415) 437-8310; Fax: (415) 437-8329; TDD: (415) 437-8311.

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 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 in our facilities. A copy of the current Notice in effect will be available at our registration areas and it is available upon request.

EFFECTIVE DATE October 01, 2019.