MID COUNTY ORTHOPAEDIC SURGERY AND SPORTS MEDICINE

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Scott W. Zehnder, M.D.

Date: ____________

PATIENT REGISTRATION
- ☐ New Patient
- ☐ Update

REFERRED TO THIS OFFICE BY:
- ☐ Patient (Name) ____________
- ☐ Doctor (Name) ____________
- ☐ ER (Hospital) ____________

Patient's Email ____________

Patient's Last Name ____________ First ____________ Middle ________ Date of Birth ________ Age ____ Sex M/F

SSN # ____________ Marital Status ________ Spouse's Name ____________ Home Phone # (____) ____________

Patient's Address ____________ (Street, City/State, Zip) Work Phone # (____) ____________ Cell Phone # (____) ____________

Patient's Employer ____________ Employer's Address ____________

PARTY RESPONSIBLE FOR BILL (AND SPOUSE) IF OTHER THAN PATIENT

Both Parents, if patient is a minor (under 21)

Last Name ____________ First ____________ Middle ____ Relationship to Patient ________ SSN # ________ Date of Birth ________

Address ____________ (Street, City/State, Zip) Phone (____) ____________

Employer's Name ____________ Employer's Address ____________ City & State ____________ Phone (____) ____________

Last Name ____________ First ____________ Middle ____ Relationship to Patient ________ SSN # ________ Date of Birth ________

Address ____________ (Street, City/State, Zip) Phone (____) ____________

Employer's Name ____________ Employer's Address ____________ City & State ____________ Phone (____) ____________

INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARD(S) AVAILABLE TO COPY

Primary Insurance Co. ____________ Effective Date ____________

ID # ____________ Group # ____________

Subscriber ____________ (First, Middle, Last) Subscriber SSN # ____________ Date of Birth ________

Secondary Insurance Co. ____________ Effective Date ____________

ID # ____________ Group # ____________

Subscriber ____________ (First, Middle, Last) Subscriber SSN # ____________ Date of Birth ________

Other Insurance Co. ____________ Effective Date ____________

ID # ____________ Group # ____________

Subscriber ____________ (First, Middle, Last) Subscriber SSN # ____________ Date of Birth ________

INJURY REPORT/NATURE OF INJURY

☐ WORKER'S COMP ☐ RECREATIONAL ☐ AUTO ☐ HOME ☐ OTHER

☐ DATE OF INJURY ____________

MID-COUNTY ORTHOPAEDIC SURGERY & SPORTS MEDICINE
PATIENT CONSENT FORM

PATIENT NAME ____
LAST FIRST MIDDLE INITIAL

SSN ____________________

1. RELEASE OF INFORMATION:

I authorize my physician to release any medical information concerning my care, including copies of medical records, and/or billing information pertaining to my medical care to individuals or representatives of agencies or organizations in connection with obtaining payment of the medical services rendered to me.

I acknowledge that this authorization has no expiration date and is valid to authorize the release of medical records and billing information.

2. ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Mid-County Orthopaedic Surgery & Sports Medicine, I hereby irrevocably transfer said physicians all insurance benefits now due and payable to me or to become due and payable to me under any insurance policy or policies, or any replacement policies thereof that might be applicable.

I authorize direct payment by any insurance company to Signature Health Services, Mid County Orthopaedic Surgery and Sports Medicine. I understand that my obligation to pay all charges is not affected by the fact that I have insurance benefits, and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing.

3. GUARANTEE OF ACCOUNT:

In consideration of any and all medical services rendered to the above named patient, I agree to pay Mid-County Orthopaedic Surgery & Sports Medicine the charges for all services ordered by physician. If I have not followed the requirements for referral, second opinions, or pre-certification of my care, as outlined by my insurance carrier, I understand that I will be responsible for all charges that I incur. In the event of nonpayment, I will be responsible for any legal or collection fees. The collection fee is a percentage of the total balance turned over to an outside agency. I agree to be responsible for these fees.

4. MEDICARE INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to Healthcare Financing Administrator or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I understand I am responsible for the Part B deductible for each year, the remaining Co-Insurance and any other amounts which may become due.

The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status, and further certifies that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement.

5. ACKNOWLEDGEMENT OF PRIVACY NOTICE:

I have been provided with a Notice of Privacy Practices that describes the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail or provide a copy of any revised notice.

____ DATE ______________
Patient's Signature/Person Authorized to Consent (Relationship)

____ DATE ______________
Guarantor of Account if other than Patient (Relationship)

I hereby certify that I have witnessed the signature of the patient and/or individual signing on behalf or for the benefit of the patient.

______________ ______________________________
Date Witness

MID COUNTY ORTHOPAEDIC SURGERY & SPORTS MEDICINE

A Division of Signature Health Services

(PEDIATRIC FORM)

(Please fill in all sections)

Name___________________________ **Date of Birth**__________ **Referring MD** ______________

Height__________ **Pediatrician**______________________

Male____ **Female**____ **Weight**__________

Please describe problem/ reason for visit:____

____

____

Date of onset/injury______________

Have any x-rays or tests been performed? YES NO If yes, list name of test:______________________

Date of test____________ Location test performed ______________________

Birth History

Weight ______lbs. ______oz

- ❑ Premature How many weeks?_______
- ❑ C-section
- ❑ Full term
- ❑ Vaginal
- ❑ Breech
- ❑ Complications (explain):

Developmental History

Please note age at which:

Rolled over	_____months
Sat independently	_____months
Stood independently	_____months
Cruised along furniture independently	____ months
Walked independently	_____months

Immunizations up to date? YES NO

Tetanus up to date? YES NO UNKNOWN

Dominant hand: RIGHT LEFT

Date of first menstrual period:____________
(N/A if not applicable)

Past Medical History (patient only)

			Reviewed Initials/Date
❑ Mitral valve prolapse			________
❑ Heart disease	❑ Stomach or intestinal ulcers	❑ Muscular Dystrophy	________
❑ Anemia	❑ Peptic Ulcer Disease	❑ Neurofibromatosis	________
❑ Stroke	❑ Crohn's Disease/ Colitis	❑ Rickets	________
❑ Bleeding disorder	❑ Irritable Bowel	❑ Spina Bifida	________
❑ Blood clots (DVT)	❑ Rheumatoid Arthritis	❑ Cerebral Palsy	________
❑ Hemophilia	❑ Hepatitis	❑ Kyphosis/ Scoliosis	________
❑ Cancer (Type:________)	❑ Liver problems	❑ Hip Dysplasia	________
❑ Psychiatric history	❑ Kidney stones/disease	❑ Legg Perthes Disease	________
❑ Anxiety	❑ Urologic problems	❑ Clubfoot	________
❑ Depression	❑ Frequent urinary infections (UTI'S)	❑ Knock-knee	________
❑ ADHD	❑ HIV+	❑ Bowleg	________
❑ Headaches	❑ Neurologic disease	❑ Diabetes-Insulin dependent?	________
❑ Lung disease/ Pneumonia	❑ Seizures	❑ Thyroid disease	________
❑ Asthma	❑ Down's Syndrome	❑ Anesthesia difficulties	________
❑ Reflux	❑ **Other** ____________________	❑ **None of the above**	________
❑ Hiatal hernia	____________________		

Hospitalizations

YES NO If yes, please list: ______________________________________

____

Surgical History

Previous surgery or procedures? YES NO If yes, list surgeon, date and type.

Operation	Surgeon	Date

PLEASE COMPLETE REVERSE SIDE

(PLEASE FILL IN ALL SECTIONS)

Family History (Please check any conditions present in biological mother, father, or siblings)

- ❑ Heart Disease
- ❑ Stroke
- ❑ Cancer
- ❑ Pulmonary Disease
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Diabetes
- ❑ Psychiatric Illness
- ❑ Anesthesia difficulties
- ❑ Blood disorder
- ❑ Pigeon-toed
- ❑ Clubfoot
- ❑ Hip Dysplasia
- ❑ Legg Perthes
- ❑ Bowleg
- ❑ Knock Knee
- ❑ Kyphosis (Roundback)
- ❑ Scoliosis
- ❑ Spondylolisthesis
- ❑ Low Back Pain
- ❑ Other ________________
- ❑ **None of the above**
- ❑ **Adopted**

Medications YES NO If yes please list with dosages: ____________________________________

____

____

Allergies Known **drug** allergies? YES NO

Known **food** allergies? YES NO

Known **latex** allergy? YES NO

Please list name of allergic medication/food/substance and the type of reaction (for example: rash, upset stomach, swelling, wheezing, shock or other type reaction): ____________________________

____

____

Social History

Parents marital status: (Please circle one) Single Married Separated Divorced Not married Widowed

Child lives with____________________________ Legal guardian: ____________________________

Number of Brothers________ Sisters________

Grade level ________ Employed? Yes No If yes, hours per week: __________

Tobacco use? Yes No Smoking in the home? Yes No

Alcohol use? Yes No Other substance use? Yes No

What sports/exercise do you participate in? ____

Current Medical Status/Review of Systems: (Please check all that apply)

- ❑ Good general health
- ❑ Recent weight changes
- ❑ Fever
- ❑ Fatigue
- ❑ Eye disease/injury
- ❑ Glasses/contacts
- ❑ Blurred/double vision
- ❑ Hearing loss/ringing
- ❑ Chronic sinus problem
- ❑ Nose bleeds
- ❑ Difficulty swallowing
- ❑ Shortness of breath
- ❑ Chest pain
- ❑ Palpitations
- ❑ Faintness
- ❑ Breathing problems
- ❑ Chronic/frequent coughs
- ❑ Wheezing
- ❑ Spitting up blood
- ❑ Change in bowel habits
- ❑ Loss of appetite
- ❑ Nausea/vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Indigestion/reflux
- ❑ Burning/painful urination
- ❑ Frequent urination
- ❑ Bloody urine
- ❑ Joint pain
- ❑ Back pain
- ❑ Pain at night
- ❑ Difficulty walking
- ❑ Muscle weakness
- ❑ Rashes
- ❑ Dry skin/itching
- ❑ Chronic skin ulcers
- ❑ Varicose veins
- ❑ Numbness/tingling
- ❑ Blackouts
- ❑ Tremors
- ❑ Paralysis
- ❑ Depression
- ❑ Memory loss or confusion
- ❑ Nervousness
- ❑ Insomnia
- ❑ Slow to heal after cuts
- ❑ Bruising tendency
- ❑ transfusions

The above information is correct and accurate to the best of my knowledge. I understand the need to inform the practice of any changes in my medical condition.

Name of person supplying info:____________________________________ **Date:** ________________________

Signature: ____
(Guardian)

MID COUNTY ORTHOPAEDIC SURGERY AND SPORTS MEDICINE
A Division of Signature Medical Group

This information is requested to satisfy the government's requirements for "meaningful use" of an electronic record. Thank you for your patience and understanding.

Race	Please Check One
	Alaskan Native
	Asian
	Black or African American
	Greek
	Hispanic or Latino (All races)
	Indian
	Multiracial (More than one race)
	Native American Indian
	Native Hawaiian
	Pacific Islander
	Unknown/Not reported
	White (Not Hispanic/Latino)

Language	Please Check One
	Arabic
	Bosnian
	Bulgarian
	Central Khmer
	Chinese
	English
	French
	German
	Haitian; Haitian Creole
	Hebrew
	Hindi
	Italian
	Japanese
	Korean
	Polish
	Portuguese
	Russian
	Somali
	Spanish; Castilian
	Swahili
	Thai
	Urdu
	Vietnamese

Patient Name:

____
Please print name

Email Address:

____
Please print

____ I do not want to receive Email from Signature Medical Group.

_____ I do not want to receive Email from my physician.

Pharmacy Information:

____
Pharmacy name

____
Pharmacy address

____
Pharmacy phone

SIGNATURE MEDICAL GROUP, INC

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____, have received a copy of Signature Medical Group, Inc.'s updated Notice Privacy Practices.

____

Printed name of patient and printed date of birth

____

Signature of patient or parent/legal guardian/legally responsible person

____

Description of relationship to the patient

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual/Representative refused to sign the form
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) ____

  ____

  ____

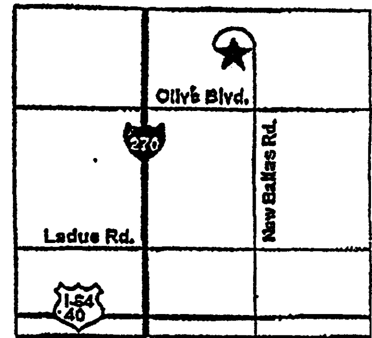
MID COUNTY ORTHOPAEDIC
SURGERY & SPORTS MEDICINE

314-983-4700
midcountyortho.com

Directions to Mid County Orthopaedic - CityPlace 5

Take highway I-270 to Olive Blvd (MO-340).Go east on Olive.
At the 2nd light, turn left (going North) onto N. New Ballas Rd.
(past Bristol's). At 1st stop sign, turn left onto American Legion Dr.
At the next stop sign, turn right & continue to CityPlace 5 (on right).
Please pull into the parking garage just past the building's main
entrance & service area. Continue up the ramp to Level 2 (green level)
to park. The parking garage entrance on Level 2 will bring you to
the 2nd floor where the receptionist will direct you to the appropriate
suite. Mid County Orthopaedic Surgery and Sports Medicine
occupies the entire 2nd floor.

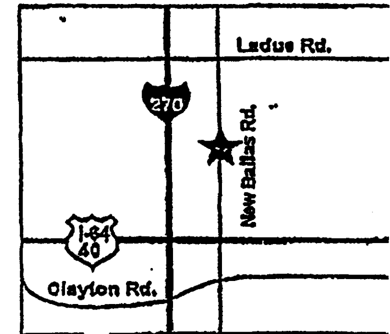
CityPlace 5
845 North New Ballas Ct
St. Louis, MO 63141
Suite 200



Directions to Mid County Orthopaedic - Ballas - Mercy

Take highway 40/I-64 to Ballas. Go north to Mercy hospital
then left into the complex. Use valet parking or park in the Ballas
parking garage and enter Tower B. Our office is easy to locate
on the main floor of Tower B as you enter the building. Suite 63.

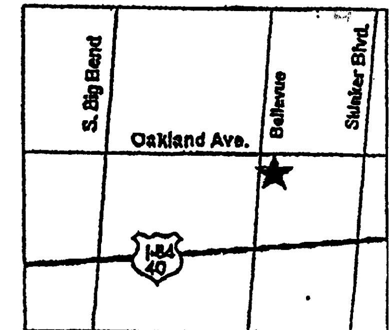
Ballas-Mercy
621 South New Ballas Rd
St. Louis, MO 63141
Tower B, Suite 63



Directions to Mid County Orthopaedic - Bellevue / St. Mary's

Take highway 40/I-64 to Bellevue exit. Go north on Bellevue to
the Bellevue Medical Plaza (on the left, just across from
St. Mary's hospital) and turn left into the plaza. We are located
in the 1027 building, suite 25 (ground floor).

Bellevue
1027 Bellevue Ave
St. Louis, MO 63117
Suite 25



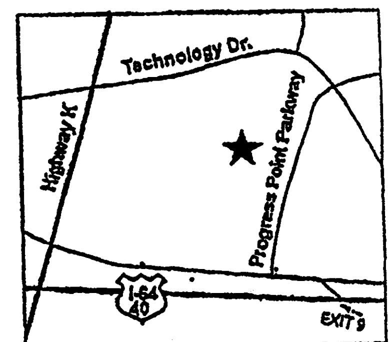
Directions to Mid County Orthopaedic - Progress West

From the East, take highway 40-164 to the Hwy K exit (exit 9).
Progress Point Parkway will be on the right BEFORE Hwy K.
Make a right onto Progress Point Parkway, then a left into the
parking lot. Use the parking lot on your right, and
ENTER THROUGH THE NEW MEDICAL BUILDING ENTRANCE.

From the West, take Hwy 40/164 to the Hwy K exit and proceed
north to the second stop light. Turn right on Technology Dr.
(between Cracker Barrel & Quik Trip).Turn right at the first roundabout
and it will take you straight to the hospital campus. Park in the
lot on your left and
ENTER THROUGH THE NEW MEDICAL BUILDING ENTRANCE.

From the North, take Hwy K south until the Waterbury Falls
stoplight (Walgreens will be on your left). Turn left on Waterbury Falls
and follow until the first roundabout. Drive straight through the roundabout
and it will take you to the hospital campus. Park in the lot on your left and
ENTER THROUGH THE NEW MEDICAL BUILDING ENTRANCE.

Once inside, follow the hall to your left. We are on the right side of the
hall in the first suite. Suite 106.



Progress West Hospital
20 Progress Point Pkwy
O'Fallon, MO 63368
Suite 106- Medical Building

SIGNATURE MEDICAL GROUP, INC. ("SIGNATURE") NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Signature. It applies to the health services you receive at Signature, including all Divisions within Signature. Signature will be referred to herein as "we" or "us." We will share your health information among ourselves to carry out our treatment, payment, and health care operations.

1. <u>**Our Privacy Obligations**</u>. The law requires us to maintain the privacy of certain health information called "Protected Health Information" (***"PHI"***). Protected Health Information is the information that you provide us or that we create or receive about your health care. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice. Furthermore, we are required to notify you following a breach of unsecured PHI.

2. <u>**Ways We Can Use and Share Your PHI Without Your Written Permission (Authorization)**</u>. In many situations, we can use and share your PHI for activities that are common in many hospitals and clinics. In certain other situations, which we will describe in Section 3 below, we must have your written permission (authorization) to use and/or share your PHI. We do not need any type of permission from you for the following uses and disclosures:

   a. **Uses and Disclosures for Treatment, Payment and Health Care Operations.** We may use and share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and perform our "Health Care Operations." These three terms are defined as:

      i. **Treatment.** We use and share your PHI to provide care and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

      ii. **Payment.** We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your health care (***"Your Payor"***) and to confirm that Your Payor will pay for health care. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent. However, if you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with Your Payor. We will follow your request unless a law requires us to share that information.

iii. **Health Care Operations.** We may use and share your PHI for our health care operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other health care providers.

iv. **Business Associates.** In addition, we may share PHI with certain others who help us with our activities, including those we hire to perform services.

b. **Your Other Health Care Providers.** We may also share PHI with your doctor and other health care providers when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.

c. **Disclosure to Relatives, Close Friends and Your Other Caregivers.** We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we: (1) first provide you with the chance to object to the disclosure and you do not object; (2) reasonably infer that you do not object to the disclosure; or (3) obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

d. **Public Health Activities.** We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

i. to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;

ii. to report abuse or neglect to government authorities, including a social service or protective services agency, that are legally permitted to receive the reports;

iii. to report information about products and services to the U.S. Food and Drug Administration;

iv. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;

v. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and

vi. to prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

e. **Health Oversight Activities.** We may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

f. **Judicial and Administrative Proceedings.** We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

g. **Law Enforcement Purposes.** We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a subpoena.

h. **Decedents.** We may share PHI with a coroner, medical examiner or funeral director as authorized by law. The personal representative of the decedent has the authority to exercise rights regarding the decedent's health information such as authorizing certain uses and disclosures of the information. We may share your PHI with a family member who was involved in your care or payment for your care prior to death, unless such disclosure would be inconsistent with any prior expression you have communicated to us. Under federal law, PHI does not include individually identifiable health information regarding a person who has been deceased for more than 50 years.

i. **Organ and Tissue Procurement.** We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

j. **Research.** We may use or share your PHI if the group that oversees our research, the Institutional Review Board/ Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to begin the research process.

k. **Workers' Compensation.** We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

l. **Disaster Relief.** We may share your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

m. **School Immunization Requests.** We may share your PHI for purposes of school immunization requests if the school is required by law to have documentation of such immunization(s) for enrollment.

n. **Fundraising.** We may contact you to raise funds for Signature Medical Group, Inc. You may tell us you do not wish to be contacted for this purpose, and will agree to remove you from the list. To do so, please contact the Privacy Officer.

o. **As required by law.** We may use and share your PHI when required to do so by any other law not already referred to above.

3. <u>Uses and Disclosures Requiring Your Written Permission (Authorization).</u>

a. **Use or Disclosure with Your Permission (Authorization).** For any purpose other than the ones described above in Section 2, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

b. **Marketing.** We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials paid for by a third party. However, we may communicate with you face to face about products or services related to your treatment, case management, or care coordination, or alternative treatments, therapies, health care providers, or care settings. For example, we may not sell your PHI without your written authorization.

c. **Uses and Disclosures of Your Highly Confidential Information.** Federal and state law requires special privacy protections for certain highly confidential information about you (***"Highly Confidential Information"***), including: (1) any portion of your PHI that is kept in psychotherapy notes; (2) about mental health and developmental disabilities services; (3) about alcohol and drug abuse prevention, treatment and referral; (4) about HIV/AIDS testing, diagnosis or treatment; (5)

about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; (9) about sexual assault; or (10) In Vitro Fertilization (IVF). Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

4. <u>Your Rights Regarding Your Protected Health Information</u>.

a. **For Further Information; Complaints.** If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our HIPAA Privacy Officer. You may also file written complaints with the Office for Civil Rights (***"OCR"***) of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not take any action against you if you file a complaint with us or with the OCR.

b. **Right to Receive Confidential Communications.** You may ask us to send PHI to a different location than the address that you gave us, or in a special way, or to contact you at a different phone number. You will need to ask us in writing. For example, you may ask us to send a copy of your medical records to a different address than your home address. We will accept all reasonable requests.

c. **Right to Revoke Your Written Permission (Authorization).** You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the Privacy Officer. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

d. **Right to Inspect and Copy Your Health Information.** You may request copies (for a reasonable fee) and/or access to your medical record file, billing records, and other records. You have a right to a copy of your records, if part of a "designated record set" in electronic format, as reasonably available. You can review your medical records and/or ask for hard copies. Under limited circumstances, we may deny you access to a portion of your records. If you want to receive a copy of your records, you may obtain a record request form from Signature. Return the completed form to your Signature provider.

e. **Right to Amend Your Records.** You have the right to request that your PHI be corrected if you believe it contains a mistake or is missing information in medical record files used to make decisions about your Treatment and payment for your Treatment. If you want to amend your records, you must tell us the reason for the change in writing by completing the amendment request form you can obtain from the Privacy Officer or your provider. After which, you can return the completed form to the Privacy Officer. We may deny your request if: (1) it does not include a reason for the change; (2) the information you want to change was not created by Signature or is not part of the medical record kept by Signature; or (3) the information contained in the record is complete and accurate.

f. **Right to Receive an Accounting of Disclosures.** You may ask for an accounting of certain disclosures of your PHI made by us. These disclosures must have occurred before the time of your request, and we will not go back more than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, we will charge you based on the rate sheet. Direct your request for an accounting to the Signature Privacy Officer.

g. **Right to Request Restrictions.** You have the right to ask us to restrict or limit the PHI we use or disclose about you for treatment, payment, or health care operations. With one exception, we are not required to agree to your request. If we do agree, we will comply unless the information is

needed to provide emergency treatment. Your request for restrictions must be made in writing and submitted to the Signature Privacy Officer. We must grant your request to a restriction on disclosure of your PHI to a health plan if you have paid for the health care item in full out of pocket.

h. **Right to Receive a Copy of this Notice.** If you ask, you may obtain a copy of this Notice, even if you have agreed to receive the notice electronically.

5. <u>Effective Date and Duration of This Notice</u>

a. **Effective Date.** This Notice is effective as of April 1, 2017.

b. **Right to Change Terms of this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in common areas throughout our facility, and on our Internet site at www.signaturemedicalgroup.com. You also may obtain any new notice by contacting the Privacy Officer.

Questions or Concerns: Please contact the Privacy Officer with any concerns or for additional information:

Privacy Officer, Jeanne Cantalin
Signature Medical Group, Inc.
314-628-1651
jcantalin@signaturehealth.net
Or at:
1-844-257-7766
compliance@signaturehealth.net