

# Black Hills Orthopedic & Spine Center, P.C.

## Notice of Privacy Practices

### **THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

1. Black Hills Orthopedic & Spine Center, P.C. is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
  - a. For treatment – certain patient health information may be referred to another provider for purposes of diagnostic testing and treatment, including but not limited to MRI or CT Scans, EMG Studies, Lab work, Surgeries, etc.
  - b. For payment – certain patient health information may be transmitted to your health insurance carrier so that billed services and payments may be transmitted directly between Black Hills Orthopedic & Spine Center, P.C. and your insurance carrier.
  - c. For health care operations – certain patient health information may be used for Clinic Management purposes, including but not limited to Quality Assurance activities, Medical Resident Education and Training purposes, Business Management and Administrative Activities, including customer service assessment.
  - d. For Individuals Involved with your care or Payment for your care - to the extent necessary, certain patient information may be shared with a family member or friend or other person(s) to help you with your health care or with payment for your health care.
2. Black Hills Orthopedic & Spine Center, P.C. is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, when required by law or to avert a serious threat to health or safety.
3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.
4. Black Hills Orthopedic & Spine Center, P.C. intends to engage in (n)one or more of the following activities:
  - a. Black Hills Orthopedic & Spine Center, P.C. may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
  - b. Black Hills Orthopedic & Spine Center, P.C. may contact the individual/Patient for certain research purposes.
  - c. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The Individual has the following rights regarding protected health information:
  - a. The right to request restrictions on certain uses and disclosures of protected health information. Black Hills Orthopedic & Spine Center, P.C. is not required to agree to a requested restriction, however.
  - b. The right to receive confidential communications of protected health information, as applicable.
  - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
  - d. The right to amend protected health information, as provided in the Privacy Regulation.
  - e. The right to receive an accounting of disclosures of protected health information.
  - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
6. Black Hills Orthopedic & Spine Center, P.C. is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
7. Black Hills Orthopedic & Spine Center, P.C. is required to abide by the terms of the Notice currently in effect.
8. Black Hills Orthopedic & Spine Center, P.C. reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Black Hills Orthopedic & Spine Center, P.C. will provide individuals or patients with a revised Notice using common public notification methods, including but not limited to, posting a copy of the currently effective Notice in the Clinic's normal place of business, direct mail or other means of public notification, including posting a notice in public newspapers.
10. Individuals may complain to Black Hills Orthopedic & Spine Center, P.C. and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows:
  - a. You may file a complaint with Black Hills Orthopedic and Spine Center P.C., or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing.
11. Black Hills Orthopedic & Spine Center, P.C.'s contact person for matters relating to complaints is:
  - a. Contact: Jan Bartscher - Patient Relations Team Leader
  - b. Address: Privacy Complaints, PO Box 6850, Rapid City, SD 57709
  - c. Phone Number: 605/341-1414
12. This Notice is first in effect on April 1st, 2003

I hereby acknowledge that I have received a copy of Black Hills Orthopedic & Spine Center, P.C.'s Notice of Privacy Practices.

---

Individual's Signature

---

Date





**PATIENT HEALTH HISTORY FORM** (Rev.1)

(Intended for BHOSC Internal Office Use Only)

Reviewed by	
<b>Physician's Signature:</b>	<b>Date:</b>

Please answer all questions and circle all relevant selections.

<b>Patient's Full Name:</b>	
<small>(First Name, Middle Initial, Last Name)</small>	<small>(Printed)</small>
	<small>(Date)</small>
	<small>(Signature)</small>
<i>Social Security #:</i>	
<i>Date Of Birth:</i>	
<i>Updated/Appointment Date:</i>	

**Past Medical History**

Please list/update all your medical illnesses, conditions and hospitalizations.

<i>Hospitalization/Illness</i>	<i>Year Diagnosed</i>	<i>Complications – Comments</i>

**Past Surgical History**

Please list/update all Surgeries, if any.

<i>Surgeries</i>	<i>Year Performed</i>	<i>Complications – Comments</i>

For any Surgeries, please answer the following:

Have you ever had General Anesthesia?	Yes – No
Have you ever experienced problems with Anesthesia?	Yes – No
If yes, please explain:	
Have any of your Family members had problems with Anesthesia?	Yes – No

**Patient Name:** \_\_\_\_\_

**Medications**

Please list all **CURRENT** Medications.

<u>Drug/Medication Name</u>	<u>Date Issued</u>	<u>Dosages</u>	<u>Reason for Medication</u>

**Allergies**

Please list/update all Allergies, including any known Drug Allergies.

- Reaction Codes:
- 1) Skin Rashes/Hives
  - 2) Nausea/Vomiting/Diarrhea
  - 3) Shock/Unconsciousness
  - 4) Anemia/Blood Disorder
  - 5) Asthma/Shortness of Breath

<b>ARE YOU ALLERGIC TO LATEX?</b>	<b>YES - NO</b>	
<u>Listed Allergies</u>	<u>Reactions</u>	<u>Comments – Descriptions</u>

**Family History**

Please list/update Family Health History.

<u>Family Member</u>	<u>Deceased</u>	<u>Age</u>	<u>Health Status or Cause of Death</u>
Grandmother (mother's)	Yes – No		
Grandfather (mother's)	Yes – No		
Grandmother (father's)	Yes – No		
Grandfather (father's)	Yes – No		
Father	Yes – No		
Mother	Yes – No		
Sister/Brother	Yes – No		
Sister/Brother	Yes – No		
Sister/Brother	Yes – No		
Sister/Brother	Yes – No		

**Patient Name:** \_\_\_\_\_

**Social History**

Please list/update your Social History.

<b><u>Question</u></b>	<b><u>Response Selections</u></b>
Height & Weight:	Height: _____ Weight: _____
Right or Left Handed:	Right - Left
Employment Status:	Employed - Unemployed - Student - Work at Home
Occupation/Place of Employment:	
Marital Status:	Single - Married - Divorced - Separated - Widow
History of Substance Abuse:	Yes - No
(If yes, please explain)	
Alcohol Use:	Yes - No (If yes, number of drinks per week: _____ )
Smoker:	Yes - No (If yes, _____ Packs per day; _____ Years as User )
Smokeless Tobacco:	Yes - No (If yes, _____ Cans per Week; _____ Years as User )

**Review of Systems**

Please indicate any current or recent problems. If yes, please describe.

<b><u>List</u></b>	<b><u>Response</u></b>	<b><u>Description/Comments</u></b>	<b><u>Treating Physician</u></b>
Eyes	Yes - No		
Thyroid Problems	Yes - No		
Ears, Nose, Throat	Yes - No		
Lungs, Breathing	Yes - No		
Digestion	Yes - No		
Stomach Ulcers/Reflux	Yes - No		
Bowel Movement	Yes - No		
Bladder Problem	Yes - No		
Diabetes	Yes - No		
Heart Problems	Yes - No		
High-Blood Pressure	Yes - No		
Stroke Problems	Yes - No		
Bleeding Problems	Yes - No		
Blood Clots	Yes - No		
Circulation Problems	Yes - No		
Balance Problems	Yes - No		
Numbness/Tingling	Yes - No		
Blackout/Fainting	Yes - No		
Psychological Problems	Yes - No		
AIDS/Hepatitis	Yes - No		
Cancer	Yes - No		
Arthritis	Yes - No		
Gout	Yes - No		
TB	Yes - No		
MRSA	Yes - No		
Epilepsy	Yes - No		
Last Menstrual Cycle			

-----**RELEASE OF PATIENT INFORMATION**-----

Regarding service I have received, I give permission for any doctor, physician assistant or staff member of Black Hills Orthopedic & Spine Center to speak to: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

-----**AUTHORIZATION FOR CONSENT**-----

I, the undersigned, voluntarily consent for the staff at Black Hills Orthopedic & Spine Center to provide treatment and/or physical therapy without parent/legal guardian accompaniment for \_\_\_\_\_.  
(Patient's Name)

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

The persons listed below are authorized by me, parent or legal guardian, to bring \_\_\_\_\_, a minor child, to this facility for medical treatment:  
(Patient's Name)

\_\_\_\_\_  
Full Name of Authorized Person

\_\_\_\_\_  
Full Name of Authorized Person

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

-----**MEDICAL AUTHORIZATIONS**-----

**MEDICARE AUTHORIZATION RELEASE:** I authorize the release of any medical records to Medicare necessary to process the claim.

Date signed: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**INSURANCE INFORMATION RELEASE:** I authorize the release of any and all medical records necessary to process the claim to my insurance carrier.

Date signed: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:** I authorize payments of medical benefits to Black Hills Orthopedic & Spine Center for services rendered.

Date signed: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

**ASSIGNMENT OF BENEFIT SIGNATURE REQUIRED FOR ALL SERVICES PROVIDED. AUTHORIZATION WILL BE SUBMITTED TO CARRIERS ON OUTSTANDING ACCOUNTS ONLY.**

**TREATMENT RELEASE** - I authorize Black Hills Orthopedic & Spine Center and the attending Physicians to perform any diagnostic tests or procedure indicated for treatment.

Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

-----**FINANCIAL AUTHORIZATION**-----

I acknowledge full financial responsibility for services rendered by Black Hills Orthopedic & Spine Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **Black Hills Orthopedic & Spine Center, P.C.**

---

---

Thank you for choosing Black Hills Orthopedic & Spine Center for your medical needs. Our team will work hard to provide the very best service to you. We encourage you to communicate any questions or concerns during the course of your care as they arise. We provide around-the-clock comprehensive attention to your needs. Your doctor or the “on call” physician or physician assistant is available 24 hours a day for emergencies by calling our office number (605) 341-1414.

### **BHOSC PRESCRIPTION REFILL POLICY:**

#### **PRESCRIPTION MEDICATIONS: IMPORTANT – PLEASE READ**

Please plan ahead. If you anticipate needing more medication and do not have any refills on your prescription, call your doctor at (605) 341-1414 by 5:00 p.m. Monday through Thursday and by 3:00 p.m. Friday.

***THERE WILL BE NO PAIN MEDICATION OR OTHER PRESCRIPTION MEDICATIONS AUTHORIZED FOR PATIENTS AFTER 5:00 PM MONDAY THROUGH THURSDAY. THERE WILL BE NO PAIN MEDICATION OR OTHER PRESCRIPTION MEDICATIONS AUTHORIZED AFTER 3:00 PM FRIDAY.***

On Thursday, check your pain medication and make sure you have enough medication to get you through the weekend.

***THERE WILL BE NO PAIN MEDICATION OR OTHER PRESCRIPTION MEDICATION AUTHORIZED ON SATURDAY OR SUNDAY.***

***\*\*Lost Medications and prescriptions will not be replaced\*\****

I have read and understand the above policy

\_\_\_\_\_  
Patient Signature

Respectfully,  
The Physicians and Staff  
Black Hills Orthopedic & Spine Center  
Business Hours: Monday – Friday 7:00 am – 5:00 pm

# Rapid City, South Dakota

Address: 7220 South Highway 16  
Rapid City, SD 57702

Phone: 605-341-1414  
800-446-9556

