CHARLOTTESVILLE ORTHOPAEDIC CENTER
Innovation that moves you

David Nielsen, D.O.
Board-certified Orthopaedic Surgeon
Fellowship-trained in Upper Extremity
Certificate of Added Qualification (CAQ): Hand Surgery

183 Spotnap Road, Suite C | Charlottesville, VA 22911 | 434-244-8412 | www.cvilleortho.com

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / LP

Birth date: / /	Age:	Social Security no.:	Sex: ☐M ☐F	Home phone no.: ( )

Physical address:	Email Address:	Cell Phone: ( )

P.O. box/Mailing (if different):	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Other:

PCP/Family Doctor: | Is this visit result of an injury? Y ☐ or N ☐ | Date/Time of injury_____

INSURANCE/PAYMENT INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

Person responsible for bill: ☐ Self	Birth date: / /	Address (if different):

Home phone no.: ( )	Work no: ( )	Cell No: ( )	Is this person a patient here? ☐ Yes ☐ No

(Please give your insurance card to the receptionist.)

Primary insurance:	Policy no.:	Group no.:

Subscriber's name: ☐ Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary insurance:	Policy no.:	Group no.:

Subscriber's name: ☐ Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

WORKCOMP Patients (You must have proper written authorization or you may be considered a selfpay patient.)

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Authorization for Treatment, Release of Information, Insurance Authorization and Assignment & Financial Agreement

I hereby authorize treatment. I authorize Charlottesville Orthopaedic Center to furnish to insurance carriers any medical information necessary to process my claims. I hereby assign to Charlottesville Orthopaedic Center all payments, for medical good/services rendered to myself or my dependents. I understand that I am responsible for payment of any amount not covered by insurance. **AFTER INSURANCE PAYMENT IS RECEIVED, I AUTHORIZE CHARLOTTESVILLE ORTHOPAEDIC CENTER TO BILL ANY REMAINING BALANCE TO THE CREDIT CARD I PRESENT TODAY AND TO MAIL ME A RECEIPT.** I understand that an additional amount of 1% interest will be added to patient balances 30 days or more past due. I agree to reimburse the fees of any collection agency, equaling 30% of the debt, and all costs and expenses, including reasonable attorney's fees, incurred in such collection efforts. I hereby acknowledge responsibility for obtaining any referrals needed.

_____ _____

Patient or Guardian signature *Date*

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Patient Questionnaire Initial Evaluation

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. **Mark the word or phrase that best describes your situation. You may select more than one answer per question.** Answer the question in as much detail as possible. Write additional information in the margins if needed. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Patient name: _____ Date:_____

Family/primary doctor: _____ Phone: _____

Family/primary doctor's address: _____

How were you referred here? ☐ Family/primary doctor ☐ Other doctor, please name: _____

☐ Family ☐ Friend ☐ Telephone book ☐ Internet ☐ Referral service ☐ Other: _____

Age:_____ Sex: ☐ Male ☐ Female Are you pregnant? ☐ Yes (_____Weeks) ☐ No

Are you breastfeeding? ☐ Yes ☐ No

What are you seeing the doctor for? _____

Is this injury work related? ☐ Yes (date/time of injury)_____ ☐ No

When did the problem first start or when did the injury occur? _____

Explain in your own words how this problem occurred: _____

_____

_____

Have you seen a doctor for this problem or injury? ☐ Yes ☐ No If yes, who and when?

_____

What treatments have you had (tests, medication, surgery, therapy, splinting, etc)? Please include everything from previous providers as well as anything you may have done on your own. ☐ None ☐ Yes, please explain: _____

_____

_____

_____

_____

_____

_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? Please check all that apply:

☐ Fevers	☐ Headaches	☐ Vomiting	☐ Bladder or urination problems
☐ Fatigue	☐ Shortness of breath	☐ Diarrhea	☐ Skin, hair or nail changes
☐ Infections	☐ Productive cough	☐ Constipation	☐ Bruising or bleeding
☐ Night sweats	☐ Chest pain	☐ Weight loss	
☐ Vision changes	☐ Chest palpitations	☐ Weight gain	☐ **I do not have any of these symptoms**

PLEASE TELL US ABOUT YOUR PAST ORTHOPAEDIC HISTORY (not including today):

- ☐ Shoulder fracture ☐ Left/Right ☐
- ☐ Shoulder injury ☐ Left/Right ☐
- ☐ Shoulder dislocation ☐ Left/Right ☐
- ☐ Rotator cuff strain/bursitis ☐ Left/Right ☐
- ☐ Rotator cuff tear ☐ Left/Right ☐
- ☐ Adhesive capsulitis/frozen shoulder ☐ Left/Right ☐

- ☐ Arm fracture ☐ Left/Right ☐
- ☐ Arm injury ☐ Left/Right ☐
- ☐ Elbow fracture ☐ Left/Right ☐
- ☐ Elbow injury ☐ Left/Right ☐
- ☐ Tennis elbow ☐ Left/Right ☐
- ☐ Forearm fracture ☐ Left/Right ☐
- ☐ Forearm injury ☐ Left/Right ☐

- ☐ Finger fracture ☐ Left/Right ☐
- ☐ Finger injury ☐ Left/Right ☐
- ☐ Hand fracture ☐ Left/Right ☐
- ☐ Hand injury ☐ Left/Right ☐
- ☐ Wrist fracture ☐ Left/Right ☐
- ☐ Wrist injury ☐ Left/Right ☐
- ☐ Carpal tunnel syndrome ☐ Left/Right ☐
- ☐ Trigger finger ☐ Left/Right ☐
- ☐ Ganglion cysts ☐ Left/Right ☐
- ☐ Tendon lacerations ☐ Left/Right ☐
- ☐ Nerve or artery injury ☐ Left/Right ☐

- ☐ Hip fracture ☐ Left/Right ☐
- ☐ Hip injury ☐ Left/Right ☐
- ☐ Thigh fracture ☐ Left/Right ☐
- ☐ Thigh injury ☐ Left/Right ☐

- ☐ Knee injury ☐ Left/Right ☐
- ☐ Meniscal tear ☐ Left/Right ☐
- ☐ ACL ligament injury ☐ Left/Right ☐
- ☐ Leg fracture ☐ Left/Right ☐
- ☐ Leg injury ☐ Left/Right ☐

- ☐ Ankle fracture ☐ Left/Right ☐
- ☐ Ankle sprains ☐ Left/Right ☐
- ☐ Foot fracture ☐ Left/Right ☐
- ☐ Foot injury ☐ Left/Right ☐
- ☐ Toe fracture ☐ Left/Right ☐
- ☐ Toe injury ☐ Left/Right ☐

- ☐ Herniated disc
- ☐ Back fracture
- ☐ Low back pain
- ☐ Neck fracture
- ☐ Neck injury
- ☐ Other, please specify: _____

_____

☐ **NO PREVIOUS ORTHOPAEDIC PROBLEMS**

PLEASE TELL US ABOUT YOUR PAST MEDICAL HISTORY:

- ☐ Coronary artery disease
- ☐ Peripheral vascular disease
- ☐ Past heart attack
- ☐ Chest pain
- ☐ Arrhythmia/Irregular heart beat
- ☐ Heart murmur
- ☐ Heart valve dysfunction
- ☐ Pacemaker
- ☐ Heart failure
- ☐ Fainting spells

- ☐ Hypertension/High blood pressure
- ☐ High cholesterol
- ☐ Adult onset diabetes
- ☐ Childhood onset diabetes
- ☐ Stroke/TIA

- ☐ DVT/Blood clot
- ☐ Bleeding problems
- ☐ Sickle cell disease
- ☐ Anemia
- ☐ Blood transfusion

- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Shortness of breath
- ☐ Pneumonia

- ☐ Growth problems
- ☐ Developmental delay
- ☐ Congenital anomalies

- ☐ Stomach ulcer
- ☐ Reflux/GERD
- ☐ Gastritis
- ☐ Hiatal hernia
- ☐ Colitis
- ☐ Chron's disease
- ☐ Irritable bowel syndrome
- ☐ Diverticulitis
- ☐ Diarrhea
- ☐ Pancreatitis
- ☐ Cirrhosis
- ☐ Liver disease
- ☐ Alcoholism
- ☐ Hepatitis A/B/C
- ☐ Kidney disease
- ☐ Kidney stones

- ☐ Enlarged prostate
- ☐ Endometriosis
- ☐ Menopause
- ☐ Gynecologic problems

- ☐ Anxiety
- ☐ Depression
- ☐ Migraines
- ☐ Parkinson's
- ☐ Seizure disorder
- ☐ Multiple sclerosis

- ☐ Cancer, specify type:

_____

_____

- ☐ Head injury
- ☐ Paralysis/spinal cord injury
- ☐ Immune disorder
- ☐ Thyroid disease

- ☐ Glasses/contacts
- ☐ Blind
- ☐ Cataracts
- ☐ Detached retina
- ☐ Glaucoma

- ☐ Deaf/Hard of hearing
- ☐ Hearing aid use
- ☐ Vertigo
- ☐ Seasonal allergies
- ☐ Nose bleeds
- ☐ Sinusitis

- ☐ Osteoarthritis (age related)
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Fibromyalgia/Chronic pain
- ☐ SLE/Lupus

- ☐ Bone infections
- ☐ Chronic/Non-healing wounds
- ☐ Burn injury
- ☐ Other condition, please list:

_____

_____

☐ **NO MEDICAL PROBLEMS**

PLEASE TELL US ABOUT YOUR PAST SURGICAL HISTORY: Place a mark beside any surgery you have ever had.

General Surgery

	YEAR		YEAR
☐ Appendectomy	_____	☐ Hernia repair	_____
☐ Cataract extraction	_____	☐ Hysterectomy	_____
☐ Caesarian section	_____	☐ Mastectomy	_____
☐ Angioplasty	_____	☐ Tonsillectomy	_____
☐ Bypass/open heart surgery	_____	☐ Prostate surgery	_____
☐ Peripheral vascular surgery	_____	☐ Other, please specify:	_____
☐ Gall Bladder surgery	_____		

☐ **NO PREVIOUS GENERAL SURGERY**

Orthopaedic Surgery

		YEAR			YEAR
☐ Shoulder: fracture repair	☐ Left/Right ☐	_____	☐ Hip: fracture repair	☐ Left/Right ☐	_____
☐ Shoulder: arthroscopy	☐ Left/Right ☐	_____	☐ Hip: total hip replacement	☐ Left/Right ☐	_____
☐ Shoulder: rotator cuff repair	☐ Left/Right ☐	_____	☐ Thigh	☐ Left/Right ☐	_____
☐ Clavicle	☐ Left/Right ☐	_____	☐ Knee: fracture repair	☐ Left/Right ☐	_____
☐ Arm	☐ Left/Right ☐	_____	☐ Knee: arthroscopy	☐ Left/Right ☐	_____
☐ Elbow	☐ Left/Right ☐	_____	☐ Knee: ACL reconstruction	☐ Left/Right ☐	_____
☐ Forearm	☐ Left/Right ☐	_____	☐ Knee: total knee replacement	☐ Left/Right ☐	_____
☐ Hand/Wrist: fracture repair	☐ Left/Right ☐	_____	☐ Leg	☐ Left/Right ☐	_____
☐ Hand/Wrist: carpal tunnel	☐ Left/Right ☐	_____	☐ Ankle	☐ Left/Right ☐	_____
☐ Hand/Wrist: nerve repair	☐ Left/Right ☐	_____	☐ Foot	☐ Left/Right ☐	_____
☐ Hand/Wrist: tendon repair	☐ Left/Right ☐	_____	☐ Toes	☐ Left/Right ☐	_____
☐ Finger	☐ Left/Right ☐	_____	☐ Other, please specify:		_____
☐ Low back	☐ Left/Right ☐	_____	_____		
☐ Neck	☐ Left/Right ☐	_____			

☐ **NO PREVIOUS ORTHOPAEDIC SURGERY**

PLEASE TELL US ABOUT YOUR FAMILY HISTORY:

Has any blood relative had any of the following conditions? Place a mark beside any condition, and fill in type if known

☐ Dysplasia , type: _____	☐ Congenital musculoskeletal , type: _____
☐ Bone diseases , type: _____	☐ Neurologic disorders , type: _____
☐ Connective tissue disorders , type: _____	☐ Bone cancer , type: _____
☐ Mucopolysaccharidosis , type: _____	☐ Other cancer , type: _____
☐ Muscular dystrophies , type: _____	☐ Other please list: _____
☐ Blood disorders , type: _____	

☐ **NEGATIVE FAMILY HISTORY**

PLEASE TELL US ABOUT YOURSELF:

Occupation:_____ ☐ Retired Employer_____

☐ Disabled (cause: _____) ☐ Permanent ☐ Temporary

Hand dominance: ☐ Right ☐ Left ☐ Ambidextrous

Education completed:
- ☐ Elementary school
- ☐ High school
- ☐ GED
- ☐ Vocational school
- ☐ College
- ☐ Graduate school

Marital status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Partner
- ☐ Widow

Children:
- ☐ None
- ____# son(s)
- ____# daughter(s)

Home arrangements:
- ☐ Home, alone
- ☐ Home with family
- ☐ Home with roommates
- ☐ Assisted living, name: _____
- ☐ Nursing home, name: _____

What best describes your activity level? (Check only one)
- ☐ 30 minutes of an exercise program less than 1 day a week
- ☐ 30 minutes of an exercise program 1-2 days a week
- ☐ 30 minutes of an exercise program 3 or more days a week
- ☐ Active but no exercise program
- ☐ Sedentary/sit most of the day
- ☐ Minimal activity outside of home
- ☐ Stay at home only
- ☐ Stay in bed only

What assistive devices do you use? (Check all that apply)
- ☐ **None**
- ☐ Cane
- ☐ Crutches
- ☐ One-handed walker
- ☐ Full walker
- ☐ Rollator
- ☐ Wheelchair

Do you now, or have you ever used tobacco? ☐ Yes (years _____) ☐ No ☐ Quit (year _____)

Type:	Amount: (pack/can/each)	Frequency:
☐ Chew	☐ <1	☐ Daily
☐ Cigar	☐ 1	☐ Weekly
☐ Cigarette	☐ 2	☐ Monthly
☐ Dip	☐ 3	☐ Occasionally
☐ Pipe	☐ >3	☐ Socially

Do you now, or have you ever consumed alcohol? ☐ Yes ☐ No ☐ Quit (year _____)

Type:	Amount: (glasses/servings)	Frequency:
☐ Beer	☐ <1	☐ Daily
☐ Liquor	☐ 1	☐ Weekly
☐ Mixed drinks	☐ 2	☐ Monthly
☐ Wine	☐ 3	☐ Occasionally
☐ Other: _____	☐ >3	☐ Socially

Do you now, or have you ever used recreational drugs? ☐ Yes ☐ No ☐ Quit (year_____)

Type:	Amount:	Frequency:
☐ Amphetamines	☐ <1	☐ Daily
☐ Cocaine	☐ 1	☐ Weekly
☐ LSD	☐ 2	☐ Monthly
☐ Marijuana	☐ 3	☐ Occasionally
☐ Other: _____	☐ >3	☐ Socially

Place a mark beside any medication listed below to which you are allergic:

	Reaction		Reaction
☐ Penicillin	_____	☐ Radiographic Dyes	_____
☐ Keflex (Cephalexin)	_____	☐ Adhesive Tape	_____
☐ Sulfa	_____	☐ Latex	_____
☐ Erythromycin	_____	☐ Metal	_____
☐ Morphine	_____	☐ Other, please specify:	_____
☐ Codeine	_____	_____	_____
☐ Iodine/Betadine	_____	_____	_____

☐ **NO KNOWN ALLERGIES**

What medications are you currently taking? Please include both prescription and non-prescription medications.

☐ I take no prescription or over-the-counter medications

Medications	**(MG)**	**# Times a Day**

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.

IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD

AT CHARLOTTESVILLE ORTHOPAEDIC CENTER, PLC

Charlottesville Orthopaedic Center, P.L.C.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. PLEASE READ IT CAREFULLY.

Charlottesville Orthopaedic Center, PLC, employees, medical staff, and other health care professionals are committed to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our general duties and privacy practices with respect to protected health information. This notice applies to all records of your care generated by the practice. In addition, any business associates or partners with whom we share protected health information is contractually obligated to follow the terms and conditions of this Notice.

We are required by law to abide by the terms of this Notice, and we reserve the right to change the terms of the Notice, making any revisions applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised Notice at the practice and will make paper copies of this Notice of Privacy Practices for Protected Health Information available at the practice.

How your medical information will be used and disclosed

For Treatment: We may use your medical information to provide you with treatment or services, as well as disclose your medical information to clinicians (e.g. doctors, nurses, technicians, medical students) who are involved in your care at our practice or at outside practices upon request. We may disclose your information to hospitals or other clinical facilities to coordinate your care, such as X-rays, prescriptions, labs. We may disclose medical information about you to people who may be involved in your medical care such as family members or others provide who provide services that are part of your care.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to, and payment may be collected from, you, an insurance company, medical supply company or third party. For example, we may tell your health plan about a treatment you are going to receive for pre-authorization or to see if your plan covers it. We may disclose your information to other treating providers for their payment purposes, such as the lab.

For Health Care Operations: We may use and disclose your medical information for operational reasons such as quality improvement, legal review, utilization review. This is necessary to run the practice and ensure quality care. For example, your information may be used and disclosed to review our treatment and services, to evaluate our performance, or for accrediting agencies to evaluate our practice. We may also disclose information to medical providers and other practices for review and learning purposes.

Appointment Reminders: To help you remember your appointments, our office staff may use your information in order to call you for a reminder. If you want to restrict where we can call, please let us know. If you do not want us to leave a voice mail, please let us know as well.

Release of Information in Transfer of Care: If you are transferring your care to another physician and need to have copies of your records sent, we will provide this service

with a fee for the copying charges, mailing costs, fax costs and work involved by staff members. Costs may be up to $15 or more.

Email: If you would like to communicate with email, you must be aware that email may not be secured. If you choose to use email, please let us know and provide us with your correct email address.

Treatment Alternatives: We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you, or about health-related benefits or services.

Individuals Involved in Your Care or Payment for Your Care: We may release your medical information to friends or family members who are involved in your medical care and/or someone who helps pay for your care. We have a form you can complete giving permission with whom you would prefer us to speak, though it may not be agreed with if your information needs to be shared for your wellbeing or finances.

We May Also Use or Disclose your Medical Information:

- when required by the US Department of Health and Human Services as part of an investigation or determination of the practice's compliance with relevant laws
- for public health activities including: the reporting of diseases, injury, or disability, the reporting of domestic violence or child abuse or neglect, and the conduct of public health surveillance, investigation and/or intervention
- to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings
- in the course of certain judicial or administrative proceedings
- for law enforcement purposes such as complying with a court order, subpoena or warrant, and other law enforcement purposes
- to a coroner, medical examiner or funeral director
- to an organ donation and procurement organization if you are an organ donor
- to researchers conducting research that has been approved by an Institutional Review Board or the practice's privacy board
- to appropriate persons to prevent or lessen a serious threat to the health or safety of another person or the public
- for military, national security, prisoner, and government benefit purposes. Note that disclosure for government benefits purposes are limited to health plans only
- as authorized by laws relating to worker's compensation or similar programs
- as may otherwise be required under federal or state law, including but not limited to disclosures under the Virginia Health Records Privacy Act

When we may not use your medical information: Except as described in this Notice, we will not use or disclose your medical information for any other purposes without your written authorization. If you do provide us with an authorization, you may revoke your authorization in writing at any time.

Your Rights Regarding Your Medical Information:

- To request restrictions on certain uses and disclosures of your medical information. However, we are not required to agree with your requested restriction
- To receive communications in a confidential manner
- To inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable copy fee.
- To request an amendment of your medical information. We may deny your request for certain specific reasons, and if denied, we will provide you with a written explanation for the denial and information regarding further rights you would have at that point.

- To receive an accounting of the disclosures of your medical information made by us in the six years prior to your request, except for disclosures of treatment, payment, or operational purposes, and for certain other specific disclosure types.
- To request a paper copy of this Notice of Privacy Practices for Protected Health Information
- To complain to the practice and/or the US Department of Health and Human Services if you believe that the practice has violated your privacy rights. To complain to the practice, please contact the Privacy Officer at (434) 244-8412 or by writing 183 Spotnap Road, Suite C, Charlottesville, VA 22911. If you choose to file a complaint, you will not be retaliated against in any way.

Virginia Law requires health care providers to notify you that Hepatitis B and C or HIV (AIDS) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility. "As a health care provider under Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Charlottesville Orthopaedic Center, PLC is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease control, may transmit human immunodeficiency virus or Hepatitis B and C, Charlottesville Orthopaedic Center will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed. When a person is tested, we automatically test for Hepatitis B and C and HIV for safety of all concerned. Hospital and Charlottesville Orthopaedic Center policy protects you as a patient, should you be exposed."

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact the Privacy Officer at (434) 244-8412 or in writing: 183 Spotnap Road, Suite C, Charlottesville, VA 22911.

This notice is effective as of April 14, 2003.

PROTECTED HEALTH INFORMATION (HIPAA)

I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY CHARLOTTESVILLE ORTHOPAEDIC CENTER, PLC AND its MEDICAL STAFF FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I give consent to Charlottesville Orthopaedic Center, PLC and other providers involved in my care to use and/or disclose my protected health information for the purposes of treatment, payment and health care operations. I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information, and other information used, in whole or in part, to make decisions about me. Charlottesville Orthopaedic Center, PLC Notice of Privacy Practices provides more information about how the Practice, its medical staff, and other providers may use and disclose my protected health information for these purposes. Also I have been provided information about Virginia law about policy for Hepatitis B and C or HIV testing if there is an exposure.

I acknowledge that I have received or been offered a copy of Charlottesville Orthopaedic Center, PLC Notice of Privacy Practices.

Signed by:
- ◯ Patient ◯ Spouse ◯ Parent ◯ Guardian
- ◯ Power of Attorney ◯ Other _____
- ◯ Patient is unable to sign or acknowledge
- ◯ Patient refuses to sign but was given the opportunity to acknowledge and sign

Print: _____

Signed: _____

Witness: _____

Date: _____

Chart Number_____

SHARING INFORMATION WITH FAMILY & FRIENDS

To protect the confidentiality of our patients, we ask you to fill out this section. Please indicate who you will allow us to discuss your medical care with. If you do not let us know who we may talk to, we will not discuss your medical care with them.

People we may talk to about your medical care:

Name	Relation
_____	
_____	

People we may NOT talk to about your medical care:

Name	Relation
_____	
_____	

_____

Signature Date