TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: (_____) _____-_____ CELL PHONE #: (_____) _____-_____ SECONDARY PHONE #: (_____) _____-_____

EMAIL ADDRESS: _____ Race _____ Ethnicity: Hispanic Not Hispanic

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one)
SELF SPOUSE CHILD OTHER

SEX: (circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ WORK PHONE #: (_____) _____-_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ NSURED'S DATE OF BIRTH: _____/_____/_____

Medical Information Release Form

Name:_____ Date of Birth:_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and the claims information. This information may be released to:

[ ] Spouse_____

[ ] Child (ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] My home [ ] My cell number_____

If unable to reach me

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ]_____

The best time to reach me is (day)_____ between (time)_____

Signed:_____ Date:_____

Witness:_____ Date:_____

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR ALL OF MY MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE, IN THE OPINION OF Tuscaloosa Orthopedic and Joint Institute, LLC, AND/OR FOR ASSISTING IN ANY REIMBURSEMENT OR MEDICAL BENEFITS TO WHICH PATIENT MAY BE ENTITLED. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO Tuscaloosa Orthopedic and Joint Institute, LLC, MD, PC SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY Tuscaloosa Orthopedic and Joint Institute, LLC, MD, PC. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

I AUTHORIZE TREATMENT BY Tuscaloosa Orthopedic and Joint Institute, LLC, MD, PC, PHYSICIANS AND PERSONNEL.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE AUTHORIZATION. THIS AUTHORIZATION IS VALID FOR ONE YEAR.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ DATE: _____

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____

TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE, LLC

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

1. I authorize _____ to disclose the above named individual's health information as described below to Dr. Bryan King, Tuscaloosa Orthopedic & Joint Institute, LLC, 3515 Watermelon Road, Tuscaloosa, AL 35473 or by fax to: (205)722-5594.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   ☐ Entire record ☐ Other: _____

   ☐ X-ray and imaging reports

   ☐

   ☐

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed at the request of the individual.

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Neal Griffin, Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact Tina Johnson, Privacy/Security Officer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Legal Representative Name

For Healthcare Organization Use Only

Date Received: _____

Staff Member Processing Request and Date Released _____

Patient Name:_____

Patient General Consent Form

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physicians, his/her associates or assistants of Tuscaloosa Orthopedic & Joint Institute, LLC.

_____ _____

Patient Signature Date

_____ _____

Person other than patient Relationship to Patient

Assignment of Benefits and Guarantee of Account: In consideration of all services and supplies provided by Tuscaloosa Orthopedic & Joint Institute, LLC, I understand and agree that I have full responsibility to pay Tuscaloosa Orthopedic & Joint Institute, LLC. I understand that the charges not covered by my insurance remain my responsibility and assign insurance benefits to Tuscaloosa Orthopedic & Joint Institute, LLC. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance. I accept the fees charged as a legal and lawful debt and agree to pay said fee. I agree to reimburse Tuscaloosa Orthopedic & Joint Institute, LLC the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I agree, in order for Tuscaloosa Orthopedic & Joint Institute, LLC to coordinate my care, service my account or to collect monies I may owe, Tuscaloosa Orthopedic & Joint Institute, LLC and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges. Tuscaloosa Orthopedic & Joint Institute, LLC may also contact me by sending text messages or emails, using any e-mail address I provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

_____ _____

Patient Signature Date

_____ _____

Person other than patient Relationship to Patient

Notice of Privacy Practices Receipt: I have received the Notice of Privacy Practices provided by Tuscaloosa Orthopedic & Joint Institute, LLC.

_____ _____

Patient Signature Date

_____ _____

Person other than patient Relationship to Patient

Office staff – collect copies of insurance card(s) and driver's license

Tuscaloosa Orthopedic & Joint Institute

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Height: _____ Weight: _____

Race: ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○ Other
○ Unknown ○ Decline to Answer

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○
Thumb	○ Right	○ Left	Foot	○ Right	○ Left		
Index	○ Right	○ Left	Great Toe	○ Right	○ Left		
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left		
Third	○ Right	○ Left	3rd Digit	○ Right	○ Left		
Little	○ Right	○ Left	4th Digit	○ Right	○ Left		
			5th Digit	○ Right	○ Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

4. Have you been seen in an ER for this problem? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Other/Comments: _____

_____

_____

 Patient Name: _____

Select all previous hospitalizations/surgeries: ○ None

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
TotalShoulderReplacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

				None for all None	Comments
1) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	_____
2) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	_____
3) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
4) CV	○ Chest Pain	○ Palpitations		○	_____
5) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	_____
6) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
7) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
8) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
9) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
10) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
11) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	_____

 Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? ○ Current, every day smoker ○ Current, some day smoker ○ Former smoker ○ Never ○ Heavy tobacco smoker ○ Light tobacco smoker

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

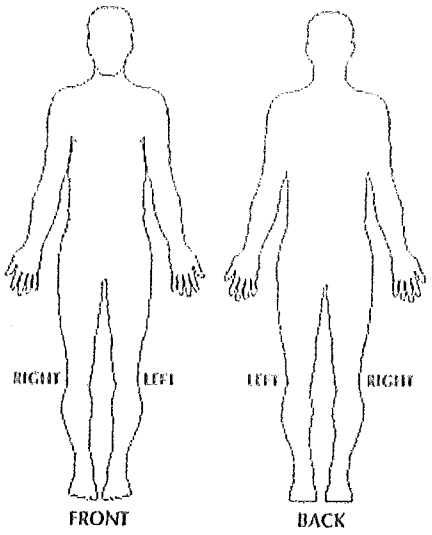
Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ Student

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____	Last A1C: _____	○ Stroke / TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

Notice of Privacy Practices

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

The policy of Tuscaloosa Orthopedic and Joint Institute, LLC is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Tuscaloosa Orthopedic and Joint Institute, LLC.

Individually identifiable health and personal information are any information obtained by Tuscaloosa Orthopedic and Joint Institute, LLC in connection with providing healthcare treatment, obtaining payment and related health care operations. This relates to past, present or future information that Tuscaloosa Orthopedic and Joint Institute, LLC receives from you as our patient.

Tuscaloosa Orthopedic and Joint Institute, LLC collects personal information in order to learn about your medical history, medical conditions, render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow up and appointment reminders, as well as treatment alternatives or other health-related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. We will obtain your authorization before using your information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. We also maintain information about you in your medical chart. Tuscaloosa Orthopedic and Joint Institute, LLC limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the Tuscaloosa Orthopedic and Joint Institute, LLC Privacy/Security Officer.
- Federal, state or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purposes such as licensure, certification, audits, investigations and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities or for coroners or funeral director to carry out their duties.

We are obligated to abide by the terms of this notice. We will contact you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. We will notify you in the event you are affected by an unsecured breach of information. We reserve the right to change the terms of this Notice of Privacy Practice and to make new notice provisions effective for all health information that we maintain.

With some exceptions, you have right to inspect, review or obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive an accounting of the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. Tuscaloosa Orthopedic and Joint Institute, LLC is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Privacy/Security Officer Tina Johnson at (205) 722-5591. You have the right to file a complaint with Office for Civil Rights and there will be no retaliation for filing a complaint.

Other optional uses of PHI:

- ❑ Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You will be contacted prior the use of your information in a research study.
- ❑ We may contact you for fundraising opportunities and you have the opportunity to opt-out of such communications.

- ☐ In order to coordinate your care or service your account, Tuscaloosa Orthopedic and Joint Institute, LLC and our agents may contact you by telephone at any telephone number you provide, including wireless telephone numbers, which could result in charges. Tuscaloosa Orthopedic and Joint Institute, LLC may also contact you by sending text messages or emails, using any e-mail address you provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.