

Dear Patient,

Thank you for scheduling an appointment with Dr Neff. It is my pleasure to welcome you to Central Iowa Orthopaedics in advance of your first visit.

Following is some information that will help familiarize you with our practice.

Central Iowa Orthopaedics
1601 NW 114th St. Ste 142
Clive, IA 50325

Phone: 515-222-3151
Toll Free: 877-348-9341
Fax: 515-222-3155
www.centraliowaortho.com

Practicing physicians
Scott B. Neff, D.O., FAAOS

Specialty
General Orthopaedic Surgery

Business hours
Monday-Thursday 8-5, Friday 8-3

Payment policy

It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. This may only be your copayment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept American Express, Mastercard, and Visa.

Copayment: This is the cost-sharing part of your bill that is a fixed dollar amount designated by your insurance company that is your responsibility to pay at each visit (also known as a copay).

Deductible: This is the amount of cost sharing that you must pay for medical services, often before your health insurance company starts to pay.

Coinsurance: The part of your bill, in addition to a copay, that you must pay. Coinsurance is usually a percentage of the total medical bill—for example 20%.

If you have any questions after reading this information, please contact our office prior to your visit by telephone at (515) 222-3151.

Please bring the following information to your visit, if you have not already given it to us prior to your scheduled visit:

- Insurance card(s)
- Driver's license or other photo identification
- Completed patient history form
- Completed privacy form

We appreciate your selecting Dr Neff for your medical care and will work hard to serve your needs.

Sincerely,

Central Iowa Orthopaedics

Appointment Requirements:

- Patients under the age of 18 **will not** be treated by our physician without a parent or legal guardian present
- Current insurance card and photo I.D.
- Co-payments must be paid at the time of check in
- Complete list of **all** medications including vitamins and herbal supplements
- If a minor is insured by parent or guardian not living in the home, the insurance card or a copy of both sides of the card must be presented at the time of the appointment
- Non-English speaking person(s) should arrange for a bilingual person 18 years or older to accompany them to appointments, we do not have bilingual staff
- Copies of any previous testing including x-ray films and reports
- Uninsured patients are expected to pay in full at the time of service
- All non-covered services by insurance are the patient's responsibility
- If Workman Compensation is responsible for fees incurred, pre-authorization is required, if this is not done the patient is responsible for all Central Iowa Orthopaedic fees
- If third party liability is responsible for fees incurred, pre-authorization is required, if this is not done the patient is responsible for all Central Iowa Orthopaedic fees
- Short term and long term disability forms and FMLA papers require \$10 payment each for completion by nursing staff
- We accept cash, check, Visa, MasterCard and American Express

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Des Moines, IA 50325
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SCOTT B. NEFF, D.O., FAAOS
 Diplomate, American Board of Orthopaedic Surgery
 Fellow, American Academy of Orthopaedic Surgeons
 Fellow, American Academy of Disability Evaluating Physicians
 Certified, American Board of Independent Medical Examiners

AUTHORIZATION TO RELEASE INFORMATION

Patient Name _____ Birth Date _____ Medical Record # _____

I request access to my personal health information covering the dates ___/___/___ through ___/___/___

I hereby authorize *Central Iowa Orthopaedics* to disclose and deliver to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Purpose for disclosure: Personal Use Continued Patient Care Insurance Attorney/Legal Disability

I ACKNOWLEDGE THE INFORMATION TO BE RELEASED MAY INCLUDE MATERIAL PROTECTED BY FEDERAL AND/OR STATE LAW APPLICABLE TO SUBSTANCE ABUSE, MENTAL HEALTH, AND/OR AIDS/HIV-RELATED INFORMATION.

I specifically authorize the release of confidential information relating to the following (place Yes or No in all spaces):

- _____ Substance Abuse (drug or alcohol) Information
- _____ Mental Health Information
- _____ HIV/AIDS-Related Information, Diagnosis, & Test Results

Federal and/or State law specifically require that any disclosure of substance abuse, alcohol/drug, mental health, or HIV/AIDS related information must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply. This consent will automatically expire one year from date signed. I understand that if I revoke, the revocation will take effect on the day it is received the entity from whom disclosure is sought in writing.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE DESCRIBED ABOVE

Signature of Patient/Representative

Relationship to Patient

Date of Request

Medical Record Overview

Both the **HIPAA Privacy Rule** and the Iowa regulations give you rights to your medical records. The HIPAA Privacy Rule sets standards that apply to records held by **healthcare providers** across the nation. Iowa regulations set some standards for records held by doctors within the state. Most healthcare providers must follow both the HIPAA Privacy Rule and Iowa regulations. If a standard in the Iowa regulations conflicts with a standard in the HIPAA Privacy Rule, your healthcare provider must follow the standard that is the most protective of your rights.

Summary Of Your Rights:

In Iowa, you have the right to:

- **See and get a copy of your medical record.** Your healthcare provider usually must let you see your medical record or give you a copy of it no later than 30 days after they receive your request. This right is called the **right to access** your medical record.

Your healthcare provider is allowed to charge you a fee for copying your record and copies of x-rays. They can also charge you the actual cost for postage if you have the copy mailed to you.

- **Have information added to your medical record to make it more complete or accurate.** This is called the **right to amend** your record. In certain cases, your provider can deny your request to amend your record. If this happens, you have the right to add your own short statement to your medical record.

Getting Your Medical Record

Your **healthcare provider** has up to but no longer than 30 days after your request for your record.

Requesting your record requires a medical record release/request form to be completed in writing. Once your request is received it will be completed in the order it was received.

When you ask for your medical record, your request should include:

- If you will be picking up your record or want it mailed to you
- The date of your requesting
- Your name, address, telephone number, date of birth and any previous name you may have used (such as your maiden name)
- Date(s) of treatment or service
- A description of the information that you want a copy of. This might include:

Whether you want the entire record or just part of the record
Medical condition for which you are asking information
Specific test results
Copy of plain film x-rays

Verifying your identity will be required before any medical record is received if you are requesting to pick them up.

If you are acting under a durable power of attorney, you are required to show a copy of the form.

Your records will not be sent to you by email or facsimile because of HIPAA regulations.

CIO PATIENT MEDICAL HISTORY

Today's Date _____ Updated Date _____

Name _____ Birth date _____

PERSONAL HISTORY OF ILLNESS:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy(seizure) | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Skin Trouble | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | _____ |

SURGERIES AND HOSPITALIZATIONS

Year/Surgery or reason for hospitalization

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

ALLERGIES

Are you allergic to any medications? No Yes

If yes, what? _____

Do you have any other allergies? No Yes

If yes, what? _____

MEDICATIONS

Please list name, dose, prescribing physician, and reason for taking all medications you are presently taking, including nonprescription drugs, birth control pills, and vitamins.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

FAMILY HISTORY

<u>Disease</u>	<u>Which Relative</u>	<u>Disease</u>	<u>Which Relative</u>
Cancer	_____	Heart Disease	_____
Stroke	_____	High Blood Pressure	_____
Diabetes	_____	Blood Clots	_____
Bleeding Tendency	_____	Allergies	_____
Asthma	_____	Reaction to Anesthesia	_____
Depression	_____	Other	_____

SOCIAL HISTORY

Married Widowed Single Divorced Occupation _____

Number of children _____ Exercise _____ Caffeine _____

Alcohol use/amt _____ Tobacco _____ Recreational Drug Use _____

Who referred you to our office? (Please include city or phone) _____

Who is your family physician? (Please include city or phone) _____