

Asheville Arthritis and Osteoporosis Center, P.A.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

If you have questions about this Notice, please contact the Privacy Officer at (828) 258-9533 or by mail at 4 Vanderbilt Park Dr, Suite 200 Asheville, N.C. 28803

Effective Date: April 14, 2003

Revised: 10/7/2021

We are committed to protect the privacy of your protected health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website at www.ashevillearthritis.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of a military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.

Other uses and disclosures of your health information.

- Business Associates: Some services are provided through the use of contracted entities called "Business Associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment Reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

AAOC participates in the North Carolina Health Information Exchange Network, called NC HealthConnex, which is operated by the NC Health Information Exchange Authority (NC HIEA). We will share your protected health information, or PHI, with the NC HIEA and may use NC HealthConnex to access your PHI to assist us in providing health care to you. We are required by law to submit clinical and demographic data pertaining to services paid for with funds from NC programs like Medicaid and State Health Plan. We may also share other patient data with NC HealthConnex not paid for with State funds. If you do not want NC HealthConnex to share your PHI with other health care providers who are participating in NC HealthConnex, you must opt out by submitting a form directly to the NC HIEA. Forms and brochures about NC HealthConnex are available in our office and online at NCHealthConnex.gov. You may also contact our Privacy Office at (828)210-8758. Again, even if you opt out of NC HealthConnex, we still will submit your PHI if your healthcare services are funded by State programs. Your patient data may also be exchanged or used by the NC HIEA for public health or research purposes as permitted or required by law. For more information on NC HealthConnex, please visit NCHealthConnex.gov/patients

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclose will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. Request should be addressed to the Practice Administrator at Asheville Arthritis & Osteoporosis Center, 4 Vanderbilt Park Dr., Suite 200, Asheville, N.C. 28803.

You have the right to see and obtain a copy of your protected health information.

This means you have the right to review or obtain a copy of your protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

Here is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Asheville Arthritis & Osteoporosis Center
Attn: Practice Administrator
4 Vanderbilt Park Dr., Suite 200
Asheville, N.C. 28803

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 17, 2013.

PLEASE DO NOT MAIL THIS PAPERWORK BACK TO US.
YOU MAY BRING IT IN AT THE TIME OF YOUR APPOINTMENT. THANK YOU!



ASHEVILLE ARTHRITIS
Asheville Arthritis & Osteoporosis Center

4 Vanderbilt Park Drive • Suite 200 • Asheville, NC 28803
Tel. 828-258-9533 • Fax 828-253-4434 • www.ashevillearthritis.com

New Patient Registration Form

(Please Print)

PATIENT INFORMATION

Last Name: _____	First Name: _____	Middle Name: _____
Mailing Address: _____	City: _____	State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____	Work Phone: _____
Date of Birth: ____/____/____	Age: _____	Gender at time of birth: <input type="checkbox"/> M <input type="checkbox"/> F Social Security Number: _____
Employer Name: _____	Employer Phone: _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Email: _____	
Spouse Last Name: _____	Spouse First Name: _____	
Spouse Date of Birth: ____/____/____	Spouse Social Security Number: _____	

IN CASE OF EMERGENCY

Name of Emergency Contact Person: _____	Relationship to Patient: _____
Home Phone: _____	Cell Phone: _____ Work Phone: _____

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's Last Name: _____	First Name: _____	Middle Name: _____
Mailing Address: _____ <small>(if guarantor's address is different from patient's address)</small>	City: _____	State: _____ Zip: _____
Guarantor's Phone: _____	Relationship to Patient: _____	Date of Birth: ____/____/____
Guarantor's Social Security Number: _____		

INSURANCE INFORMATION

(INSURANCE CARDS ARE REQUIRED AT EACH VISIT)

Primary Insurance Company: _____	Policy Subscriber's Name: _____ <small>(if other than patient)</small>	
Policy Number: _____	Group Number: _____	Policy Subscriber's Employer: _____
Policy Holder's Date of Birth: ____/____/____	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____ <small>(please specify)</small>	
Secondary Insurance Company: _____	Policy Subscriber's Name: _____ <small>(if other than patient)</small>	
Policy Holder's Date of Birth: ____/____/____	Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____ <small>(please specify)</small>	
Policy Number: _____	Group Number: _____	Policy Subscriber's Employer: _____

OTHER INFORMATION

Primary Care Physician: _____	Address: _____
Referring Physician: _____	Address: _____
Pharmacy Name: _____	Pharmacy Location: _____
Pharmacy Phone Number: _____	Pharmacy Card Number: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

*I hereby authorize Asheville Arthritis & Osteoporosis Center, P.A. to furnish information to Insurance Carriers concerning my illness and treatments and I hereby assign to Asheville Arthritis & Osteoporosis Center, P.A. all payments for medical services rendered to myself or my dependents, if not paid in full at the time of service. I understand that I am responsible for any amount not covered by insurance on assigned claims.

Date: _____ Signature: _____

PATIENTS WITH MEDICARE, PLEASE SIGN MEDICARE AUTHORIZATION ON BACK SIDE



4 Vanderbilt Park Dr., Suite 200
Asheville, NC 28803
Ph: 828-258-9533
Fax: 828-253-4434

ASSIGNMENT OF BENEFITS and ASSIGNMENT OF RIGHTS TO PURSUE ERISA

I, _____, hereby assign and transfer to Asheville Arthritis Center, any and all rights to payment for medical services rendered to me by Asheville Arthritis Center. I authorize my insurance carrier, including any and all supplemental insurance, to make payment directly to Asheville Arthritis Center.

I understand that I am financially responsible for any services not covered by my insurance. I also understand that I am responsible for any deductible, co-payment, or co-insurance amount as specified by my insurance policy.

I further authorize the release of any medical or other information necessary to process claims.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.
Asheville Arthritis and Osteoporosis Center

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payment. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named healthcare provider any and all Plan documents, summary benefits description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefit, health insurance or tortfeasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I received from the above-named care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about fact or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against liable party, insurance company, employee benefit plan, health care plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare, and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name

Patient Date of Birth

Signature

Date

**ASHEVILLE ARTHRITIS
AND
OSTEOPOROSIS CENTER**

PATIENT INFORMATION CONSENT FORM

I have received a copy of Asheville Arthritis and Osteoporosis Center's (AAOC) Notice of Privacy Practices. AAOC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment (TPO). With this consent, AAOC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. AAOC may also mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations. AAOC will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions.

With this consent, I grant AAOC permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____ Date of Birth: _____

Mobile Number: _____

Signature of Patient: _____

Or

Legal Guardian: _____ Date: _____

Please list any other persons that you authorize to have access to your medical records.

Name	Relationship
------	--------------

Name	Relationship
------	--------------

Name	Relationship
------	--------------

For the convenience of our patients, AAOC offers online bill pay. With this consent, I authorize AAOC to contact me by email, text, or phone (including an automatic dialing system or artificial/prerecorded voice) at the mobile number listed for notification of patient balances due. I understand I am not required to sign or agree to this as a condition of treatment.

Signature: _____



ASHEVILLE ARTHRITIS
Asheville Arthritis & Osteoporosis Center

Please Complete All 7 Pages
Front and Back

Patient Information

Date: _____

Name: _____

Address: _____

Age: _____ Race: _____

Do you currently reside in a skilled nursing facility? Yes No

Does your office visit require an interpreter? Yes No

Do you reside in another state part of the year? If so which state and what dates are you here locally? _____

Primary Care Physician:

Other Physicians you CURRENTLY see:

Please indicate who referred you here: _____

Please give a brief reason for your visit here: _____

Do you have any family members who are presently patients being treated at Asheville Arthritis? Yes No

Surgical History:

List any orthopedic surgeries. Include dates, who performed them, what hospital and what state:

Circle any surgical procedures you have had, please give dates and who performed them, what hospital and what state:

- | | |
|--|-----------------------------|
| Appendectomy | Stomach Surgery |
| Breast Surgery | Heart Surgery |
| Gall Bladder Removed | Tubal Ligation (tubes tied) |
| Hysterectomy | Ovaries removed |
| Kidney Surgery | Prostate Surgery |
| Parathyroid Surgery | Vasectomy |
| Thyroid Surgery | Recent Oral Surgery |
| Cataract Surgery | Weight Loss Surgery |
| Implant Surgery- ie. Pacemaker/Defibrillator | D&C (dilation & curettage) |

Any other surgeries, please list: _____

Have you been hospitalized in the past year? If yes, please include dates and reason for hospitalization: _____

Circle any that you have had: physical therapy, water therapy, chiropractor, acupuncture

Have you had any falls inside or outside of you home in the last year? If so did you require medical care?

Family History

Mother: Living Deceased _____ Father: Living Deceased _____
 Age or age when deceased: _____ Age or age when deceased: _____

How many siblings do you have? Brothers living: _____ Deceased: _____
 Sisters living: _____ Deceased: _____

Are your siblings healthy? _____

How many children do you have? Sons living: _____ Deceased: _____
 Daughters living: _____ Deceased: _____

Are your children healthy? _____

Please place letters in appropriate box below, if any family members have had any of the following:

M-Mother **F**- Father **MM**- Maternal Grandmother
MF- Maternal Grandfather **PM**- Paternal Grandmother **PF**- Paternal Grandfather
B- Brother **S**- Sister **S**- Son **D**- Daughter

Disease	Parents	Grandparents	Siblings	Children
General Osteoarthritis				
Rheumatoid Arthritis				
Connective Tissue Disease (Lupus, Scleroderma or other)				
Gout				
Stroke				
Breast Cancer				
Heart Disease				
High Blood Pressure				
Diabetes				
Crohn's or Ulcerative Colitis				
Osteoporosis (thin bones)				
Psoriasis, Eczema (type of rash)				
Cancers (type)				
Other Disease Processes				

Check the appropriate box and add additional explanation needed for symptoms you are CURRENTLY having:

Symptom	Yes	No	Explanation if needed
Chills			
Significant change in appetite			More or Less?
Decreased energy level			
Recent fever			
Night sweats			
Recent infections			What type?
Significant change in weight (unintentional)			Up or Down?
Environmental Allergies			
Eye dryness			
Eye pain			Which eye?
Recent vision changes			
Eye redness			Which eye?
Frequent nose bleeds			
Mouth dryness			
Ulcers in your mouth, nose			
Headaches or recent change in headaches			Migraines?
Pain in temples or jaw			
Coughing			
Shortness of breath			
Chest pain			
Increased swelling in lower legs			When?
Stomach pain			
Blood in stool			
Diarrhea or constipation			Which one?
Difficulty swallowing			
Blood clot requiring medication			
Swollen lymph nodes			
Blood in your urine			
Painful urination			
Genital Ulcers			
History of Fracture			
Patchy hair loss			
Fingers and toes that get cold and turn blue, white or red			
Rash			
Skin rash caused by sunlight			
Muscle weakness, numbness and /or tingling			Which one?
Seizures			
Symptoms of depression			
Problems going to sleep or staying asleep			Which one?