

Richard W. Vanis, M.D.

Diplomate Board of
Orthopedic Surgeons

Sports Medicine
Joint Replacement

OUT OF NETWORK PROVIDER AGREEMENT

I **understand** that Richard W. Vanis, M.D. (James Stubblefield, PT) **is not a provider** for any PPO organization. He is a provider for Medicare only.

I understand that my insurance will reimburse Dr. Vanis through my **“out of network”** benefits. Dr. Vanis will bill for his services. I will be responsible for the difference between what is charged and the amount my insurance company pays.

I understand that my insurance company may reimburse me directly for the money owed to Dr. Vanis. If this occurs, I will endorse the check and send it to his office/ send him a check directly (within 3 days) after receipt of the check from the insurance company. An interest of 10% per month will be applied if the insurance check or the amount sent by insurance is not forwarded within 3 days.

I agree that I am responsible for all charges incurred regardless of when and how much my insurance company pays on my claim(s), account no later than thirty days from the date of service.

I, _____, authorize Richard W. Vanis, M.D. to deposit checks received on my account when the insurance company has made them out to me for payment on this account.

Patient Signature

Date

PATIENT RECORD OF DISCLOSURES

Name: _____	<input type="checkbox"/> Female <input type="checkbox"/> Male	DOB: _____
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I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- Work Telephone _____
 - O.K. to leave message with detailed information
 - Leave message with call-back number only
- Written Communication
 - O.K. to mail to my home
 - O.K. to mail to my work/office

I authorize and consent to treatment or procedure(s), which have been explained to me by Richard W. Vanis, M.D., P.C. (James Stubblefield, P.T.)

Patient Signature

Date

Richard W. Vanis, M.D.

NOTICE OF PRIVACY PRACTICES RICHARD W. VANIS, M.D., JAMES STUBBLEFIELD, P.T.

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

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **requesting a form and filling it out.**

Richard W. Vanis, M.D.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Our Responsibilities

RICHARD W. VANIS, M.D AND JAMES STUBBLEFIELD, P.T. are required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem:

If have questions and would like additional information, you may contact the privacy officer at 626-574-9745. If you believe your privacy rights have been violated; you can file a complaint with the privacy officer or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date: **April 14, 2003**

WRITTEN ACKNOWLEDGEMENT

I acknowledge that I have reviewed the **Notice of Privacy Practices** which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient or Legal Representative

Physician or Authorized Representative

Date

Date

Richard W. Vanis, M.D.

HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE?

NO/YES

GENERAL INFORMATION:

Name: _____

- Sex: Male/Female Date of birth: ____/____/____
- Marital status: Single/married/divorced/separated/other
- Race or genetic heritage: _____
- Height: _____ inches Weight: _____
- I am Right handed/Left handed/Ambidextrous

Social Security number: _____

Driver's License: State: _____ Number: _____

Home address: _____

City: _____ State: _____ Zip: _____

Country (if not USA): _____

Email address: _____

Telephone

- Home: _____ Work: _____
- Cell: _____

Patient's Employer

- Name: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Job title: _____ Describe work activity: _____

Current Type of Job (Please circle) Student Homemaker Sedentary (sit down)

Physical (heavy labor, lifting, walking, climbing) Retired from: _____

Work Status

- Presently off work Since: ____/____/____
- Was off work From: ____/____/____ To: ____/____/____
- Off work due to present orthopedic problem: _____
- Off work due to other problem: _____

Personal Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Who referred you to this office? _____

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IN CASE OF EMERGENCY – PLEASE NOTIFY:

Name: _____

Relationship: _____

Phone#: _____

INSURANCE & BILLING INFORMATION

Is this due to an accident? YES NO

Is this a Worker’s Compensation Case? YES NO

Is this a Legal or 3rd Party Case? YES NO

Is this a No-Fault Accident? YES NO

RESPONSIBLE PARTY FOR PAYING BILL &/OR INSURANCE SUBSCRIBER

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Responsible Party’s birth ____/____/____

Relationship to Patient: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Medication	Dosage(tablets/capsules)	Times/day
NONE		

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES OF PATIENT-NONE

Allergic to: _____ Allergic to: _____

Allergic reaction: _____ Allergic reaction: _____

Means of control: _____ Means of control: _____

Are you allergic to adhesive tape? **YES NO** Are you allergic to Iodine? **YES NO**

LIFESTYLE

	Amount	Amount
Coffee/Tea/Caffeine drinks	_____	Tobacco products (circle all that apply)
Alcoholic beverages	_____	Cigarettes _____
Other substances: _____	_____	Cigars _____
		Snuff _____
		Chewing _____

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PLEASE RATE YOUR OVERALL LEVEL OF PHYSICAL HEALTH (please circle)

(Compare to others in your age group) Excellent Very good Good Fair Poor

PROBLEM AREAS FOR THIS EVALUATION:

Neck Back Fingers
Shoulder Right Left Pelvis Foot Right Left
Arm Right Left Hip Right Left Toes
Elbow Right Left Thigh Right Left Other
Forearm Right Left Knee Right Left
Wrist Right Left Leg Right Left
Hand Right Left Ankle Right Left

HAVE YOU HAD OTHER ORTHOPEDIC PROBLEMS?

(CIRCLE AND/OR ADD BRIEF STATEMENT) NO

Rheumatism Severe sprain
Arthritis Bone/joint infection
Gout Chest deformity
Joint Swelling Pelvis problem
Loose body in joint Sciatica
Torn cartilage Low back problem
Torn ligaments Scoliosis
Neck Mid back problem

HAVE YOU HAD ANY OF THESE ORTHOPEDIC PROBLEMS?

(CHECK AND SPECIFY) NO YES

Soft bones Dislocated joints
Fractured bones Osteoporosis
Bone cyst Malignant
Bone tumor or cyst Tendonitis
Benign Torn tendon
Bursitis Torn muscle
Injured or pinched nerve

HAVE YOU HAD OPEN ORTHOPEDIC SURGERY NOT RELATED TO PRESENT CONDITION? NO YES

Type of surgery Hospital/city
Body part Doctor
Diagnosis Date
Results

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WHEN WAS YOUR LAST COMPLETE PHYSICAL?

Date _____/_____/_____ Diagnosis (problem)_____

Doctor _____ Results_____

ANY HOSPITALIZATIONS, OTHER THAN FOR SURGERY? NO YES

Diagnosis (problem) _____ Diagnosis (problem)_____

Doctor _____ Doctor _____

Hospital/city _____ Hospital/city_____

Date _____/_____/_____ Date_____/_____/_____

Have you ever had a blood transfusion? YES NO

WHAT KIND OF ANESTHESIA HAVE YOU HAD BEFORE?

- YES NO YES NO YES NO
Saddle Block Local Spinal
General (completely asleep) Pentothal
Adverse reaction to anesthesia?
High body temperature during surgery?

HAVE YOU EVER HAD? IF YES, WHEN?

- YES NO YES NO YES NO
Heart Disease? Heart Attack? Thyroid disease
Angina, chest pain? High Blood Pressure Frequent headaches?
Stroke? Mental disease? Lung disease?
Nerve or muscle disease? Emphysema?
Arms fall asleep easily? Bronchitis?
Fainting spells? Asthma?
Pulmonary embolus? Tuberculosis?
Difficulty moving arms/legs? Glaucoma?
Shortness of breath?

(MEDICAL HISTORY cont')

- YES NO YES NO
Drug addiction? Drug withdrawal?
Easy bruising/bleeding? Kidney disease?
Hepatitis (yellow jaundice?) Diabetes?
Phlebitis? Sickle cell disease?
Positive HTLV-III virus? Other? _____

Describe:_____

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FAMILY HISTORY

YES NO

- Has anyone in your family has a tendency to bleed excessively?
- Has anyone in your family had unusual reactions to anesthesia?
- Has anyone in your family had unexplained fevers during surgery?

CERTIFICATION OF AUTHENTICITY:

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT WITHIN THE BEST OF MY ABILITY.

Patient Signature

Date

THANK YOU

WHEN COMPLETED, PLEASE RETURN TO THE RECEPTIONIST...

Thank you for allowing us to share in your care. This is a team effort and the more you can tell us, the better we can understand. The more questions you ask, the better you can understand.

Dr. Vanis is available anytime he is in town.

However, please save routine questions or pharmacy refills for routine hours. Please obtain pharmacy refills two (2) days ahead.