Jack L. Siegel, MD, FAAOS
James E. Dowd, MD, FAAOS
Nicholas A. Midis, MD, FAAOS
Kevin F. Bonner, MD, FAAOS
Louis C. Jordan, MD, FAAOS
Samuel P. Robinson, MD, FAAOS
Joseph S. Gondusky, MD, FAAOS
Justin W. Griffin, MD

Louis R. Jordan, MD, *Emeritus*
David B. Young, MD, *Emeritus*

Debra K. Brown, MBA, FACMPE
Administrator

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

Ronald E. Nave, PA-C
Linda J. Liebold, PA-C
Angela A. Rivera, NP-C
Kara P. Hood, PA-C
Sabrenia E. Gill, PA-C
Derek W. Joyner, OA-C

JORDAN RESEARCH FOUNDATION
Kevin F. Bonner, MD, FAAOS
Director of Clinical Research
Carolyn Maynes Battaglia, CCRC
Research Coordinator

Welcome to the **Jordan-Young Institute for Orthopedic Surgery and Sports Medicine**. Thank you for choosing us to serve your orthopedic needs. It is our pleasure to assist you in improving your quality of life with medical and surgical options that will maximize your mobility and minimize your pain.

In this packet, you will find both information about our practice and forms you must complete for us to assist in your care. **Please read these forms carefully and fully complete each one prior to your appointment. In addition to these completed forms, you will need to bring the following to your appointment:**

- Your current insurance cards
- Photo identification
- A **referral** from your primary care physician, if required by your insurance carrier
- Films and reports from any pertinent diagnostic testing, such as x-rays, MRIs, EMGs, CT scans, and bone density studies
- Any co-payment and deductible payments that your insurance coverage holds you responsible for to receive care. We accept cash, check, VISA, MasterCard, Discover and American Express. **Your appointment will be rescheduled if you cannot pay your co-pay before being seen.**

PLEASE PLAN TO ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME so that we can complete your registration, medical record and x-rays prior to your appointment with the physician. Even if you bring x-rays or other diagnostic tests with you, our physicians may require additional films to be taken in our office. Dress in comfortable clothing that will allow your physician to easily view the injured or painful areas of your body. While your physician strives to maintain a timely office schedule; please realize that some wait time may occur. Our physicians will give each patient the time necessary to understand their illness or injury and the options available for treatment.

If you have additional questions about our practice, our providers or your appointment, please visit our website at www.Jordan-YoungInstitute.com. Our office number is (757)490-4802.

Again, thank you for choosing **Jordan-Young Institute for Orthopedic Surgery and Sports Medicine**. We look forward to seeing you.

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OFFICE DIRECTIONS

Jordan Young Institute is located on **Cleveland Street off Newtown Road.** Cleveland Street from the Pembroke area ends at Clearfield. There is no direct roadway to Jordan Young Institute on Cleveland Street coming from the east.

FROM NORFOLK/PORTSMOUTH

- Take 264 East
- **Exit toward 1-64 E/Chesapeake/Newtown Road**
- Take Newtown Road NORTH exit (Exit 15B)
- On **Newtown Road**. Go three traffic lights.
- Right onto **Cleveland Street** (Patient First is on the corner)
- Jordan-Young Institute is first business building on the left (the name is on building)
- Our office is on the second floor.

FROM THE BEACH

- Take 264 West
- **Exit Newtown Road North** (Exit 15)
- Turn right onto **Newtown Road**.
- Turn right onto **Cleveland Street** (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor.

FROM CHESAPEAKE

- Take Route 64 to Route 264 exit toward Virginia Beach.
- **Exit Newtown Road** North (Exit 15B)
- On **Newtown Road.** Go three traffic lights.
- Right onto **Cleveland Street** (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor.

FROM HAMPTON AND NEWPORT NEWS AREA

- Take 64 East
- Exit **Newtown Road**. (Exit 284B)
- **Take Newtown Road North** exit (Exit 15B).
- On **Newtown Road**. Go three traffic lights.
- Right onto **Cleveland Street** (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor.

JORDAN-YOUNG INSTITUTE
5716 Cleveland Street, Suite 200
Virginia Beach, VA 23462
(757) 490-4802
www.Jordan-YoungInstitute.com

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PLEASE BRING YOUR INSURANCE CARDS AND THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

PATIENT INFORMATION

PATIENT: **ACCOUNT #:** _____

NAME: _____ MAIDEN/OTHER NAME: _____

ADDRESS _____

AGE: _____ DATE OF BIRTH: ___/___/___ □ MALE □ FEMALE MARITAL STATUS _____

HOME TELEPHONE # _____ SOCIAL SECURITY NUMBER: _____

CELL # _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER TELEPHONE # _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

SPOUSE OR RESPONSIBLE PARTY:

NAME: _____ MAIDEN/OTHER NAME: _____

ADDRESS _____

AGE: _____ DATE OF BIRTH: ___/___/___ □ MALE □ FEMALE MARITAL STATUS _____

HOME TELEPHONE # _____ SOCIAL SECURITY NUMBER: _____

CELL # _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER TELEPHONE # _____

PRIMARY HEALTH INSURANCE INFORMATION:

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY # _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER □ SELF □ SPOUSE □ CHILD □ OTHER GROUP # _____

SECONDARY HEALTH INSURANCE INFORMATION:

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY # _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER □ SELF □ SPOUSE □ CHILD □ OTHER GROUP # _____

EMERGENCY CONTACT INFORMATION:

NAME OF CONTACT _____

TELEPHONE # _____ RELATIONSHIP _____

I HEREBY CONSENT TO TREATMENT by Jordan Young Institute physicians, their associates, and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances and/or other procedures as deemed necessary.

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Jordan-Young Institute, P.C. healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

DISABILITY FORM INFORMATION

Jordan-Young Institute, P.C. staff will complete all disability and/or FMLA forms that you require, within two weeks of the date requested. We are unable to complete forms while you wait. We require all requests for completing and copying disability forms, medical records or x-rays to be pre-paid.

PATIENT AUTHORIZATION

I authorize Jordan-Young Institute, P.C. to release medical information necessary to submit my health insurance or Worker's Compensation Claims. I request that my health insurance or Worker's Compensation claims be paid directly to Jordan-Young Institute, P.C. In consideration of the services rendered, I/we agree and understand that each person(s) signing this document jointly and severable agrees to pay for all services rendered by Jordan-Young Institute, P.C. If this account is referred to an outside collection agency or attorney, then the undersigned person(s) agree and promise to pay all collection costs including attorney fees of 33 1/3 % of the principal amount due and owing when turned over for collection and do further agree to pay interest on the unpaid balance at the legal rate from the date services were last rendered. I authorize photocopies of this form to be valid as the original.

POLICY FOR FORMS COMPLETION AND THE COPYING OF NOTES AND X-RAYS

I have had the opportunity to read the Jordan-Young Institute, P.C. POLICY FOR FORMS COMPLETION AND THE COPYING OF NOTES AND X-RAYS and I understand that I may ask questions regarding this policy.

PRESCRIPTION REFILL POLICY

To request a prescription refill, please call us Monday through Friday, from 9:00a.m. to 4:00 p.m.. Please allow 24 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be ordered after hours or on weekends. Please remember to call us in advance so that we can assist you in a timely manner.

CLINICAL RESEARCH ACTIVITY

The physicians of Jordan-Young Institute are involved in clinical research studies and trials and work closely with Jordan Research Foundation. The companies sponsoring these studies and trials provide financial support for research staff as well as for activities the physicians perform outside of clinical practice. These activities may include consulting, advisory boards, giving speeches and/or presentations, or writing reports. If you would like more information please ask to speak with the Jordan Research Foundation's Research Coordinator.

Patient Signature: _____ Date: _____

Patient or Guardian's Signature: _____ Date: _____

Relationship to patient: _____

PATIENT HISTORY

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT

Patient Name: _____ Today's Date: _____
Last First Middle

Patient's Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____

Primary Care Physician's Name/Address: _____

Referring Physician's Name/Address: _____

What is your primary problem or complaint: _____

How long have you had this problem: _____

What is the severity of your pain (CIRCLE ONE): None 1 2 3 4 5 6 7 8 9 10 Unbearable

Is your pain: ☐ Improving ☐ Worsening ☐ Staying the same

What improves your symptoms or makes them worse: _____

Is this problem due to an accident: ☐ **Yes** ☐ **No**

Is this a workers comp claim: ☐ **Yes** ☐ **No**

How did the injury occur (SPORTS, WORK, MOTOR VEHICLE ACCIDENT):_____

Where did the injury occur: _____ **Date of injury:** _____

Have you had x-rays, MRIs or CTs performed elsewhere that were related to this problem: ☐ Yes ☐ No

If yes, please explain: _____

Have you been examined by a physician for this complaint before: ☐ Yes ☐ No

If yes, list physician: _____

Have you been told that you need surgery or ever had surgery related to this problem: ☐ Yes ☐ No

If yes, list physician: _____

Do you smoke: ☐ Yes ☐ No If yes, how often/how long: _____

If yes, how many packs or single cigarettes per day: _____

Do you drink alcohol: ☐ Yes ☐ No If yes, how much/often: _____

Have you ever had a drug addiction: ☐ Yes ☐ No If yes, how long ago: _____

MEDICAL AND SURGICAL HISTORY

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

Have you ever been diagnosed with:	Yes	No	List any other medical conditions/treatments below:
Diabetes Type 1 or Type 2			
Hypertension			
Asthma			
Kidney Disease			
Ulcers			
Gastritis			
Hepatitis			
HIV			
Seizures			
Bleeding disorders			
Cancer			

Please list any previous surgeries and the approximate year

Surgery	Year	Surgery	Year

Please list all medication allergies

Medication	Reaction

Please list all medications (prescriptions and over the counter) that you are currently taking

Medication	Dose	Frequency

FAMILY HISTORY

Please indicate the health status or cause of death of your family members

MOTHER _____ □Alive □Deceased
FATHER _____ □Alive □Deceased
BROTHER _____ □Alive □Deceased
SISTER _____ □Alive □Deceased
CHILD _____ □Alive □Deceased
CHILD _____ □Alive □Deceased
RELATIVE _____ □Alive □Deceased
RELATIVE _____ □Alive □Deceased

REVIEW OF SYSTEMS

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

Constitutional					Genitourinary				
Excessive fatigue		Yes		No	Difficult urination		Yes		No
Exercise intolerance		Yes		No	Kidney stones		Yes		No
Chills		Yes		No	Frequency		Yes		No
Fever		Yes		No	Urgency		Yes		No
Unexpected weight loss		Yes		No	Flank pain		Yes		No
Unexpected weight gain		Yes		No	Bleeding		Yes		No
Eyes					Painful urination		Yes		No
Glaucoma		Yes		No	Bladder infection		Yes		No
Cataracts		Yes		No	**Skin**				
Blurred/double vision		Yes		No	Lesion color change		Yes		No
Redness		Yes		No	Rash		Yes		No
Pain		Yes		No	Itching		Yes		No
ENT					Redness		Yes		No
Infected or painful teeth		Yes		No	Skin changes		Yes		No
Headache		Yes		No	Poor healing		Yes		No
Difficulty swallowing		Yes		No	**Neurological**				
Nose bleeds		Yes		No	Head injury		Yes		No
Ringing/pain in ears		Yes		No	Seizures		Yes		No
Cardiovascular					Numbness/tingling		Yes		No
Chest pain		Yes		No	Stroke		Yes		No
Heart murmurs		Yes		No	Dizziness		Yes		No
High blood pressure		Yes		No	Tremors		Yes		No
Palpitations		Yes		No	**Hematologic**				
Irregular pulse		Yes		No	Easy bleeding/bruising		Yes		No
Fainting		Yes		No	Blood clots		Yes		No
Vascular disease		Yes		No	Blood transfusion		Yes		No
Respiratory									
Asthma		Yes		No	**Endocrine**				
Snoring		Yes		No	Heat/cold intolerance		Yes		No
Cough		Yes		No	Excessive thirst/urination		Yes		No
Pulmonary edema		Yes		No	**Allergic**				
Shortness of breath		Yes		No	Reaction to foods		Yes		No
Wheezing		Yes		No	Reaction to environment		Yes		No
Pain with a deep breath		Yes		No	**Psychiatric**				
Gastrointestinal					Nervousness		Yes		No
Heartburn		Yes		No	Anxiety		Yes		No
Nausea		Yes		No	Depression		Yes		No
Vomiting		Yes		No	Hallucinations		Yes		No
Constipation		Yes		No					
Diarrhea		yes		No					
Bloody/tarry stools		Yes		No					

Patient's Signature: _____ Date: _____

Reviewed with patient

Physician's Signature: _____ Date: _____

IF YOUR VISIT IS FOR YOUR HIP OR KNEE ALSO COMPLETE THIS FORM

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

REASON FOR YOUR VISIT (HIP/KNEE) LEFT/RIGHT/BOTH FOR: _____

WHERE IS THE PAIN? (FRONT/BACK/INNER/OUTER/ALL OVER)_____

HAVE YOU TRIED ANY OF THE FOLLOWING **(SPECIFY LENGTH OF TIME/TYPE):**

☐ THERAPY_____ ☐ HOME EXERCISE _____ ☐ WEIGHT LOSS: _____/LBS

ASSISTIVE DEVICE: ☐ CANE _____ ☐ WALKER _____ ☐ BRACE _____

ANTI-INFLAMMATORY MEDICATION (PREVIOUS AND CURRENT) (**INCLUDE DURATION OF USE**)

☐ ALEVE/NAPROXEN _____ ☐ MOTRIN/IBPROFEN _____ ☐ CELEBREX _____

☐ MOBIC/MELOXICAM _____ ☐ OTHER: _____

HAVE YOU HAD **INJECTIONS** FOR THIS PROBLEM? **SELECT ALL THAT APPLY**

☐ CORTISONE/STEROID DATE OF LAST INJECTION: _____ HOW MANY TOTAL: _____

☐ VISCOSUPPLEMENTATION (I.E. SYNVISC, EUFLESSA, HYALGAN)
DATE OF LAST INJECTION: _____ HOW MANY TOTAL: _____

Have you had surgery on this body part (Scope or Other/When): _____

Have you had any other treatment not listed: _____

Have you seen other providers for this condition: (Who/When) _____

Pain at night: Y or N **Difficulty Sleeping:** Y or N **Back Pain:** Y or N

PAIN: Mild Moderate Severe Totally Disabling **LIMP**: Mild Moderate Severe Unable to Walk

NEED ASSISTANCE: None Cane at Times Cane Full Time Walker Wheelchair

HOW FAR CAN YOU WALK: Unlimited 6 Blocks 2-3 Blocks Indoor Only Unable

CAN YOU CLIMB STAIRS: Normal with the rail with difficulty Unable

CAN YOU PUT ON SOCKS AND SHOES: with ease with difficulty Unable

WHAT IS YOUR ACTIVITY LEVEL:
Bedridden Sedentary Semi-Sedentary Light Labor Moderate/Heavy Labor

What are some examples of how your pain impacts your daily life? (Things you can no longer do or do comfortably):_____

_____

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

FINANCIAL POLICY

Thank you for choosing Jordan-Young Institute for your orthopedic care. We are committed to providing you with the best patient care experience possible. As part of this goal, we would like to explain our payment policies before your treatment begins so you have the chance to ask questions before any payment obligation occurs. We feel that helping you understand your payment expectations and obligations ahead of time will help us provide you with the quality of compassion and care you expect from our practice.

For your convenience, we have answered a variety of commonly asked questions about payment policies. If you do not find the answer to your specific question, please ask to meet with our Business Office Manager or Practice Administrator.

Do you accept my insurance as payment in full?

We are participating providers with Medicare, Cigna, Sentara Optima, Blue Cross Blue Shield and Healthkeepers, Aetna, Humana, Tricare Standard, United Healthcare, VHN and PHCS. This means we will accept the insurers allowable as payment in full. **You, however, are still responsible for payment of any deductibles, co-insurance or co-pays as defined by your insurance coverage. Your office visit will be rescheduled if you are unable to pay your co-pay or provide a referral (if necessary) before you are seen.**

We do not participate with Aetna HMO, Today's Options Medicare Advantage or any of the Medicare-Medicaid dual-eligibility programs; however, we will assist you in determining your benefit coverage. We do not offer payment plans but can refer you to an external agency should you need to make such arrangements.

We do not participate with Healthkeepers Plus and Sentara Family Care.

When do I have to pay for services?

You are expected to pay all co-pays, co-insurance and unmet deductibles on the day of your visit. We accept VISA, MasterCard, Discover, and American Express as well as payment by cash or check. **If you are unable to pay, your appointment will be rescheduled.**

You are expected to pay for all non-covered services and DME Cash and Carry Items at the time of issue. We will gladly hold an item for you until you are able to pay.

May I still be seen if Jordan-Young does not participate with my insurance?

If you do not carry insurance that we participate with, your policy may have out-of-network benefits. It is your responsibility to call your insurance carrier to determine and understand your benefit coverage. Jordan-Young will file a claim to your insurance as a courtesy to you; however, we are not obligated to accept your insurance's payment as payment in full. **You may be balance billed for the difference between our charge and the amount your insurance pays.**

Do I need a referral to be seen?

Many insurance plans now provide open referral networks; however, it is **your responsibility to determine and understand if your individual insurance coverage requires a referral.** If your insurance requires a referral, you must have the referral available at the time of your appointment. If you do not have the referral with you, you will be asked to either 1) reschedule your appointment to give you time to obtain the referral or 2) sign a waiver that will make you responsible for payment in full of the charges incurred on the day's visit.

Tricare Prime patients must obtain a referral before being scheduled for an appointment.

Do I have to pay if I have been injured in an accident?

Jordan-Young does not accept legal cases or attorney liens. If you have been injured in a non-work-related accident for which you are seeking legal remedy, you will be required to pay 100% of your billed charges before being seen. **Your medical insurance cannot be billed**.

If you have been injured in a work-related accident, **it is your responsibility to obtain an award number from the state Workers' Compensation Commission** in order to ensure that your claim will be paid in full. If you are treated without the award number from the state and your payment of your claim is denied or only paid in part by your employer, you will be held responsible for the balance of your bill.

Jordan-Young accepts fee schedule payments for injured workers covered under the United States Department of Labor, Jones Act, Longshoreman's Act, and Sentara Health Systems.

May I set up a payment plan?

Payment is expected in full at the time services are rendered. **If you are not able to pay the patient responsible balance of your bill at the time of service, Jordan-Young retains the right to refer your account to AMC for collection. AMC will attempt to negotiate reasonable payment terms with you and will accept most forms of payment. If you fail to keep the agreed payment terms, further collection activities will ensue. You will be responsible for fees and any other associated costs incurred in collecting on your account.**

Co-insurance and deductible balances after insurance are expected to be paid within 30 days of receiving your first patient statement. If your account balance is still unpaid after 31 days, **your account will be referred to Account Management Company AMC for collections. AMC is not a collection agency, but rather an external bill paying service. However, if you default on your payment arrangements or do not pay your outstanding bill, your outstanding account will be immediately transferred to a collection agency. You will be responsible for the balance due on your account plus any <u>non-negotiable</u> fee assigned by the collection agency in satisfying the payment of your account balance.**

You will be responsible for contacting Credit Control Corporation and AMC at either (757)873-3332 or 1- (800)723-5431 for making time-based payment arrangements or collections payments.

What happens if I miss an appointment or have a check returned?

Jordan-Young reserves the right to charge a NO SHOW fee of $50 for any missed appointment. This fee must be paid before another appointment is scheduled.

Jordan-Young reserves the right to charge a RETURN CHECK fee of $35 for any payment by check that is returned for insufficient funds.

I have read and fully understand the policies of this office regarding payment. I agree to pay any known patient responsible obligations at the time of service or any obligations identified as my responsibility within 30 days of notification by my insurance or Jordan-Young. I understand that collection of my patient responsible balances outside these terms may be handled by an outside collection agency and I will be responsible for both the balance of the bill and any non-negotiable fees assigned for collection. I understand that I am personally responsible for following the regulations, policies and procedures of my insurance plan.

_____ _____

Patient Signature Date

_____

Printed Name

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

POLICY FOR FORMS COMPLETION AND DUPLICATION

Disability and FMLA Forms:

Please allow at least 2 weeks for the completion of these forms.

The following pre-paid charges will apply:

First Form, one page	$20.00
First Form, multi-page	$35.00
Subsequent Forms, one page (monthly or recurring)	$10.00
Subsequent Forms, multi-page (monthly or recurring)	$15.00

Medical Record Copies:

You must sign a *Medical Records Release Form* before this information can be released to any authorized agent acting on your behalf.

Please allow 1 week for these records to be released.

The following pre-paid charges will apply:

Base charge (chart retrieval, copying, Postage and labor) ***Not charged on first-time patient requests or requests from another treating physician***	$10.00
Pages 1 thru 50	$ .50 per page
Pages 51 and over	$ .25 per page

X-Ray Film Copies:

Please allow 1 week for the release of these films.

The following prepaid charges will apply:

Charge per film sheet	$5.00 per film

I have read the above stated policy of Jordan-Young Institute and understand it applies to all forms, medical records and film copies for all patients.

_____ _____

Signature of patient Date

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Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations **HIPAA**

I consent to the use or disclosure of my protected health information by Jordan Young Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jordan Young Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jordan Young Institute has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Jordan Young Institutes' Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Jordan Young Institute. The Notice of Privacy Practices for Jordan Young Institute is also provided **in the lobby** and on the group website at www.jordan-younginstitute.com. This Notice of Privacy Practices describes my rights and responsibilities and Jordan Young Institutes' duties and actions with respect to my protected health information.

Jordan Young Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have been told about and offered to receive a copy of the Notice of Privacy Practices.

Release of Information: I hereby give Jordan Young Institute permission to release information on my medical condition to the following people:

_____

(Name & Relationship)

_____

(Name & Relationship)

_____

(Name & Relationship)

I understand the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

_____ _____

Patient Signature or Personal Representative Signature **Date**

_____

Print Name of Patient or Personal Representative

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY & SPORTS MEDICINE

Parent or Personal Representative refused to sign acknowledgement

_____ Staff Initials

_____ Date

I would like to **RESTRICT DISCLOSURES** "To the Insurance Company" for services paid for out of pocket.

Patient Signature: _____

Date of Service: _____