**Joint Implant Surgeons, Inc.**

7277 Smith's Mill Road, Suite 200
New Albany, Ohio 43054
(614) 221-6331
(614) 304-2100 - Fax

Dear Friends:

Our team of professionals at Joint Implant Surgeons, Inc. welcomes you to our family. JIS is an organization of surgical and medical professionals committed to the care of individuals with degenerative and traumatic disorders of the hip, knee and shoulder. We were the first orthopaedic surgical practice in Central Ohio dedicated exclusively to performing joint replacement surgery and associative reconstructive procedures of the hip and knee. Our practice has since expanded to include evaluation and treatment of knee and shoulder disorders, joint preservations techniques, ligament reconstruction and meniscal augmentation of the knee, development of rehabilitation programs, and care of the hip fracture patient.

Our organization has flourished over the span of three decades. We feel that our growth is related to our belief in the value of excellent patient care and commitment to each individual patient's welfare. Our success has been based more than anything else on patient referrals from satisfied individuals.

Growth has produced the need to increase the services of our organization. A single surgeon or nurse cannot adequately care for the number of patients that currently exists. Therefore, an organized and well-supervised team is essential. Our team consists of skilled orthopaedic surgeons and internal medicine physicians, supported by outstanding nurse professionals, physician assistants, and physical therapists. The surgical and medical staff are supported by a competent group of business and health-related personnel.

Throughout Joint Implant Surgeons' ever increasing realm of patient care, our philosophy will simply remain: "We Care."

Sincerely:

The Staff of
Joint Implant Surgeons, Inc.

# Our JIS Physicians

**Adolph V. Lombardi, Jr., M.D., F.A.C.S.** received his bachelor's degree from Saint Joseph's University and medical degree from Temple University. He completed postgraduate training at Temple University Hospital and Albert Einstein Medical Center in Philadelphia, Pennsylvania. Dr. Lombardi pursued two Fellowships in Reconstruction of the Hip and Knee. He is a Clinical Assistant Professor at The Ohio State University in both the Dept. of Orthopaedics and the Dept. of Biomedical Engineering. He is Past President of Medical Staff Services at Mount Carmel New Albany Surgical Hospital. Dr. Lombardi lectures nationally and internationally. He is board certified and a member of the American Academy of Orthopaedic Surgeons, The Hip Society, The Knee Society, the American Orthopaedic Association, the American Association of Hip and Knee Surgeons, and the International Society of the Knee. He is Second Vice President of The Hip Society and an Oral Examiner for the American Board of Orthopaedic Surgeons.

**Keith R. Berend, M.D.**, received his bachelor's degree from Florida Southern College, and his medical degree and orthopaedic residency training from Duke University in North Carolina. Dr. Berend completed a Fellowship in Adult Reconstruction of the Hip and Knee, and was awarded the International College of Surgeons Research Scholarship in 1994. He is a Clinical Assistant Professor in the Department of Orthopaedics at The Ohio State University. He is board certified and a member of the American Academy of Orthopaedic Surgeons, The Knee Society, the American Association of Hip and Knee Surgeons, the Piedmont Orthopedic Society, and the International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine. Dr. Berend was a Hip Society-British Hip Society Traveling Fellow in 2004 and a John N. Insall Knee Society Traveling Fellow in 2005. Dr. Berend is a volunteer surgeon for Operation Walk, a charitable organization which provides medical education and free surgical treatment for patients in developing countries.

**Jason M. Hurst, M.D.**, received his bachelor's degree from Washington & Lee University and his medical degree from Georgetown University. He completed orthopaedic residency training at Duke University where he also worked in sports medicine research. Dr. Hurst completed a fellowship in joint preservation and sports medicine of the hip, knee, and shoulder at the Steadman-Hawkins Clinic in Vail, Colorado. He is a member of the American Orthopaedic Society for Sports Medicine, the Arthroscopy Association of North America, the International Society for Hip Arthroscopy, the Piedmont Society, and is board eligible for the American Board of Orthopaedic Surgeons. His clinical interests include hip, knee, and shoulder joint replacement and arthroscopy, femoroacetabular impingement, joint preservation, cartilage restoration, ACL reconstruction, rotator cuff repair, osteotomy and sports related injury. Dr. Hurst leads the Joint Preservation Institute at Joint Implant Surgeons, Inc. dedicated to the treatment of joint problems in the younger, active patient.

JOINT IMPLANT SURGEONS, INC.

7277 Smith's Mill Road, Suite 200
New Albany, Ohio 43054
(614) 221-6331
(614) 304-2100 - Fax

Dear Patient,

As you prepare for your upcoming surgery, we want to provide you with information regarding the association between orthopaedic manufacturers and Joint Implant Surgeons, Inc., its current two principals Drs. Lombardi and Berend and its emeritus principal Dr. Mallory.

Since its inception in the 1970's, Joint Implant Surgeons, Inc. and its physicians have been dedicated to reconstruction of the adult hip and knee. Our practice philosophy has always involved exemplary patient care combined with research and education. This has afforded us the opportunity to evaluate and treat thousands of patients on an annual basis. It is this type of practice pattern that has kept us at the forefront of technology. It has afforded us great insight into the implant requirements of our patients, as well as patients throughout the world. We have refined surgical technique and have designed instruments that facilitate the operative intervention. This intellectual property has been shared with and developed in conjunction with orthopaedic manufacturing. We have provided and continue to provide consulting services with orthopaedic manufacturing. We perform numerous instructional lectures on implants and surgical techniques for physicians and medical personnel. We are a host site to a number of national and international physicians who come to learn about our techniques.

Currently, Dr, Lombardi receives both royalty and consultant income from Biomet and royalty income from Innomed. Dr. Berend receives royalty and consulting income from Biomet and Dr. Mallory receives royalty income from Biomet. Drs. Lombardi and Berend use products from these companies in the care of their patients, but also use similar products from other implant manufacturers. Our selection of prosthetic requirements for patients is based on patient specific need and not on a specific implant in which we have a vested interest since we receive no financial remuneration on any implants we use personally or any implants used at facilities at which we operate.

We are members of the American Academy of Orthopaedic Surgeons (AAOS), which holds its members to extremely high ethical standards to ensure that even the appearance of a conflict of interest does not jeopardize the trust that the patients place in their physicians.

AAOS has adopted Standards of Professionalism that require orthopaedic surgeon members to identify and disclose potential conflicts of interest to their patients, the public, and colleagues. These Standards also clearly articulate how and under what circumstances AAOS members may work with and be compensated by industry, as well as the penalties for failure to comply.

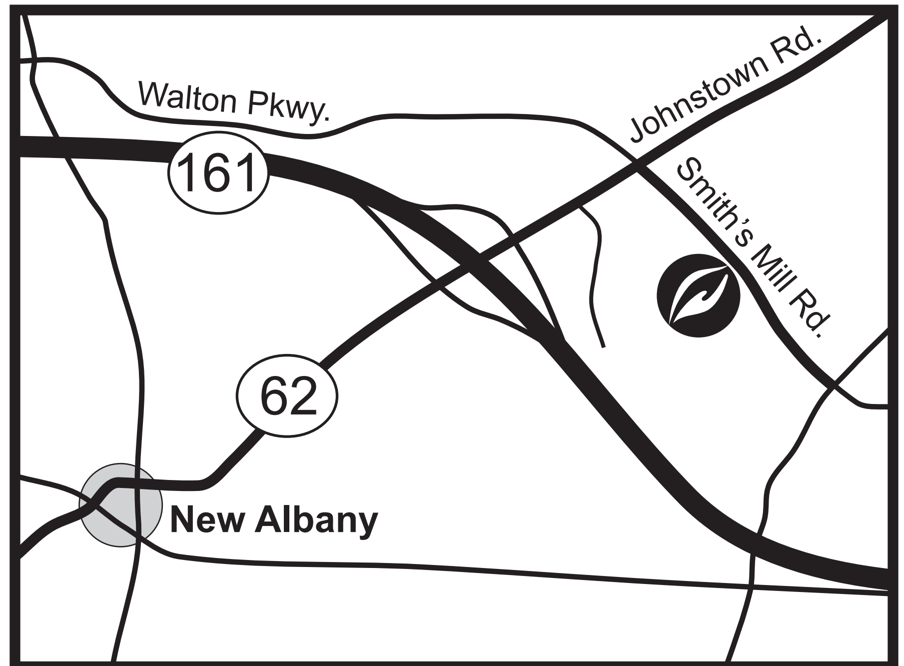
You can learn more about these Standards of Professionalism at the AAOS website:
http://aaos.org/industryrelationships/

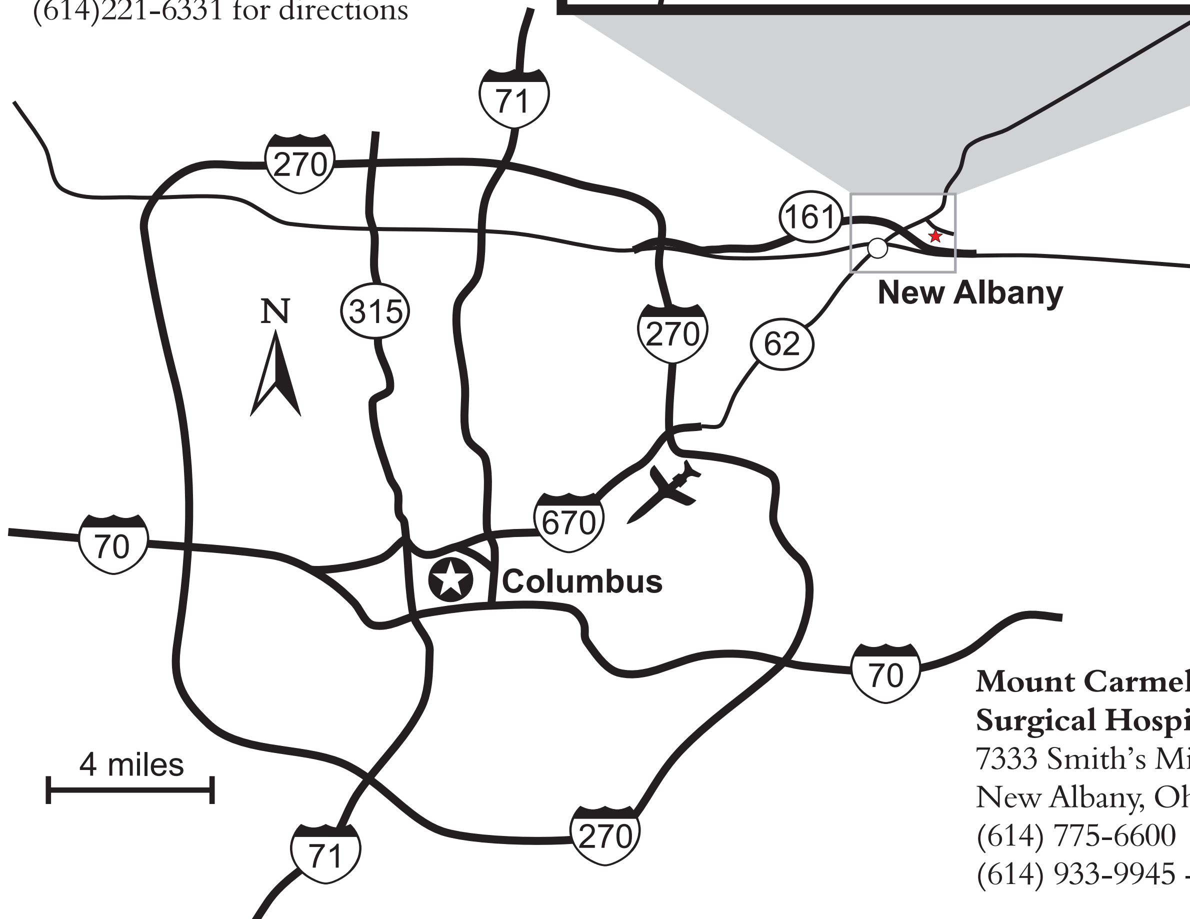
It is important to our office that you are aware of these relationships with implant manufacturers, that our office puts the interests of patients first, and that we are available to answer any questions that you may have.

7277 Smith's Mill Road, Suite 200
New Albany, Ohio 43054
(614) 221-6331
(614) 304-2100

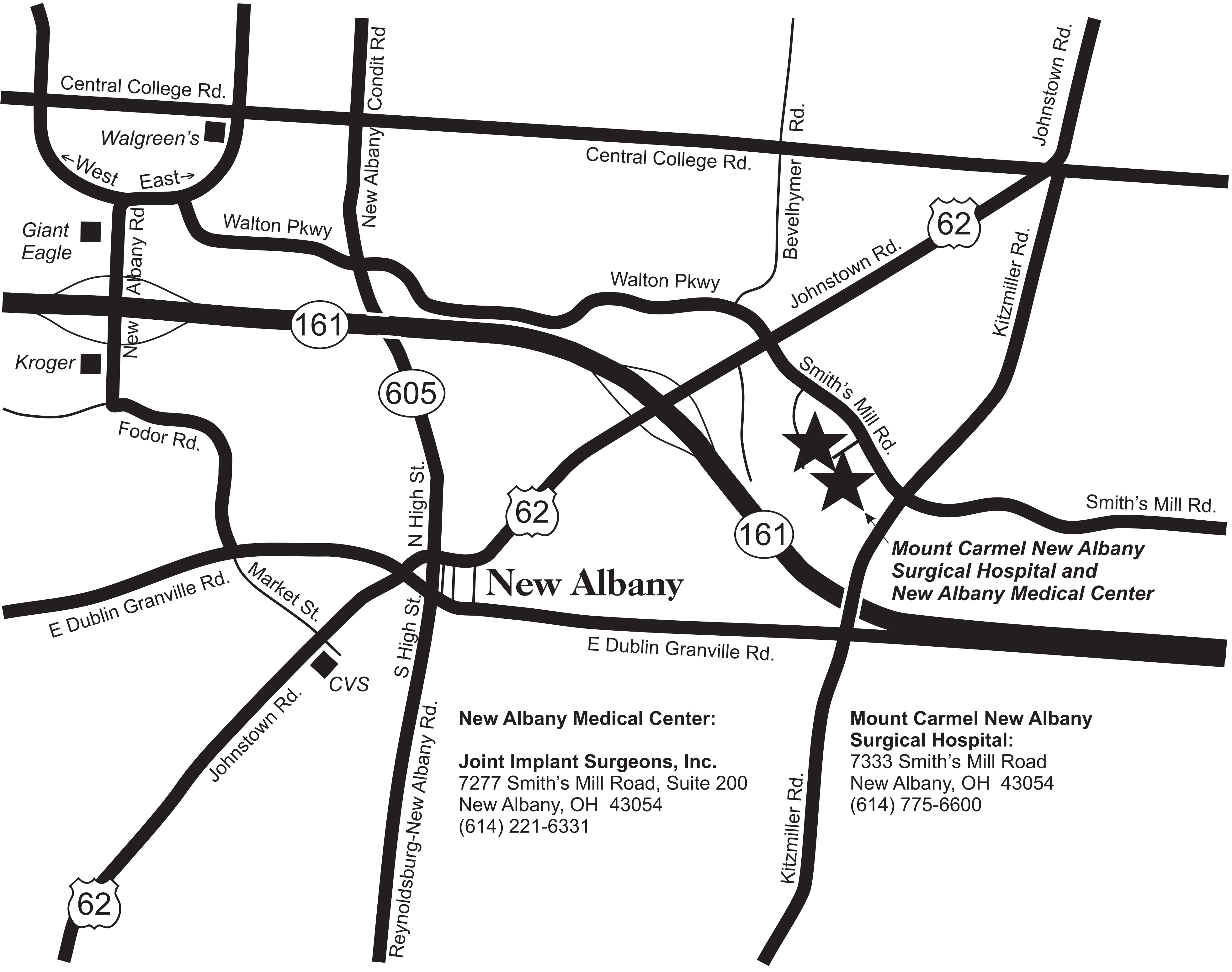
## Directions:

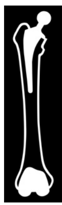
- Take I-270 to the northeast side of Columbus
- Exit at 161 East toward New Albany, and travel for approximately 5 miles
- Exit at New Albany / Johnstown, which is the second exit for New Albany
- Turn left (northeast) onto Johnstown Road (Rt. 62), toward Johnstown
- Turn right at the second light onto Smith's Mill Road
- New Albany Surgical Hospital and the New Albany Medical Center will be on the right side of the street
- **If you get lost**, please call us at (614)221-6331 for directions




**Mount Carmel New Albany Surgical Hospital**
7333 Smith's Mill Road
New Albany, Ohio 43054
(614) 775-6600
(614) 933-9945 - fax


Central College Rd.
Walgreen's
←West
East→
Giant Eagle
Kroger
New Albany Rd
New Albany Condit Rd
Walton Pkwy
161
605
62
Fodor Rd.
Market St.
CVS
E Dublin Granville Rd.
Johnstown Rd.
N High St.
S High St.
Reynoldsburg-New Albany Rd.
New Albany
Bevelhymer Rd.
Kitzmiller Rd.
Smith's Mill Rd.
Mount Carmel New Albany Surgical Hospital and New Albany Medical Center
New Albany Medical Center:
Joint Implant Surgeons, Inc.
7277 Smith's Mill Road, Suite 200
New Albany, OH 43054
(614) 221-6331
Mount Carmel New Albany Surgical Hospital:
7333 Smith's Mill Road
New Albany, OH 43054
(614) 775-6600



# Joint Implant Surgeons, Inc.

7277 Smith's Mill Road, Suite 200 • New Albany, Ohio 43054
(614) 221-6331 • Fax: (614) 304-2100

## Demographic Information

Name (First):________________________ (MI):_____________(Last):________________________________

Address (Street):____________________________________________________________________________

(City/State/Zip/Country): _____________________________________________________________________

Home Phone: (_____)________________ Mobile Phone: (_____)___________________

Email: _______________________________________________Date of Birth:________________________

Sex: ❑ M ❑ F Marital Status: ❑ M ❑ S ❑ D ❑ W Race:_________________________________________

SSN:__________________________ Referred by JIS Patient (Name):_________________________________

**Please Note:** We will be sending letters to both your family and referring physicians. Please provide complete information with respect to your physician's full name, degree (MD or DO), address, city, state and zip code. Thank you for your assistance.

### Referring Physician

Name: ______________________________________________________________Degree:_______________

Address (Street): ___________________________________________________________________________

City/State/Zip:______________________________________________________________________________

Telephone: (______) ______________________ Date of your last visit: ______________________________

### Current Family Physician

Name: ______________________________________________________________Degree:_______________

Address (Street): ___________________________________________________________________________

City/State/Zip:______________________________________________________________________________

Telephone: (______) ______________________ Date of your last visit: ______________________________

### Employment Information

❑ Employed ❑ Disabled ❑ Unemployed ❑ Retired
❑ Self-employed ❑ Student ❑ Leave of Absence Date:_________________________

Employer: _________________________________________________________________________________

Address (Street): ___________________________________________________________________________

City/State/Zip:_______________________________________________Telephone: (______) ____________

### Spouse Information

Name: ______________________________________________________________________________

SSN: ________________________________ Date of Birth: ___________________________________

❑ Employed ❑ Disabled ❑ Unemployed ❑ Retired
❑ Self-employed ❑ Student ❑ Leave of Absence Date:_________________________

Employer: _________________________________________________________________________________

Address (Street): ___________________________________________________________________________

City/State/Zip:_______________________________________________Telephone: (______) ____________

## Contact Person in Case of Emergency (Other Than Person With Whom You Reside)

Name (other than person you live with): ____________________________________________

Relationship: ____________________________________ Telephone: (_____) ___________

***Please bring your insurance cards to the appointment. Please complete all information as fully as possible.***

## Primary Insurance Carrier

Insurance Company: ________________________________________________________

Company's Address: ________________________________________________________

City/State/Zip: ____________________________________________________________

Insured's Name: _____________________________ Relationship to Patient: ______________

Insured's Address: __________________________________________________________

City/State/Zip: ________________________________ Insured's Phone: (_______)___________

Insured's Date of Birth: ______________ ID#: _______________Group #: ____________

## Secondary Insurance Carrier

Insurance Company: ________________________________________________________

Company's Address: ________________________________________________________

City/State/Zip: ____________________________________________________________

Insured's Name: _____________________________ Relationship to Patient: ______________

Insured's Address: __________________________________________________________

City/State/Zip: ________________________________ Insured's Phone: (_______)___________

Insured's Date of Birth: ______________ ID#: _______________Group #: ____________

## Industrial Claim, If Applicable

Industrial Claim Number: ___________________________ Date of Injury:______________

Employer at Time of Injury: __________________________________________________

Allowed Condition/Injury: ___________________________________________________

## Signature of Patient or Authorized Party

I authorize the release of medical information necessary to process my claim.

**X Signature:** ______________________________________ Date:________________

I authorize payment of medical benefits to Joint Implant Surgeons / Starpath Orthopaedics for service rendered.

**X Signature:** ______________________________________ Date:________________

I understand that Joint Implant Surgeons, Inc., and/or its physicians are involved in research, prosthetic design, education, and consultation services that result in reimbursement from implant manufacturers.

**X Signature:** ______________________________________ Date:________________

# Patient History



***This information is very important in your care. Please complete as carefully and accurately as possible.***

**Name** ______________________ **Date** ______________________

1 History of Present Illness
What is the problem you are being seen for today? ______________________

Location ☐ Left ☐ Right ☐ Knee ☐ Hip ☐ Back
Other ______________________

Severity of pain (if present)
☐ mild ☐ moderate ☐ severe
☐ constant ☐ intermittent ☐ with activity
Other ______________________

Duration (how long have you had symptoms)
days ________ months ________ years ________

Associated signs/symptoms ______________________

2 Please list all prior surgeries ***or*** ☐ No previous surgeries

| Year | Surgery | Year | Surgery |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

3 Please list all hospitalizations ***or*** ☐ No previous hospitalizations

| Year | Reason for hospitalization | Year | Reason for hospitalization |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

4 List all medical Illnesses you are currently being treated for (high blood pressure etc).
☐ No medical illnesses

| Condition | How Long | Condition | How Long |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

revised 7/1/2009, © Joint Implant Surgeons, Inc.

5 List all current medications you are now taking or have taken in the last two weeks
(including over the counter, herbal medications, inhalers and breathing equipment)

☐ No Medications

| Medication | Strength/dose | Times per day | Reason you are taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*(Please use separate sheet if additional space is needed)*

ALLERGIES OR SENSITIVITIES to Medications: (example: Penicillin : rash)

☐ No Known Medication Allergies

| Name of Medication | Reaction |
|---|---|
| | |
| | |
| | |

6 Height ______________ Weight ______________

7 Have you received any blood transfusions in the past? ☐ Yes ☐ No
IF Yes - did you have any adverse reaction to the transfusion? ☐ Yes ☐ No
*Please explain/describe reaction*

8 Do you have any religious beliefs against receiving blood? ☐ Yes ☐ No
*IF Yes - Please explain/describe*

9 Have you had any difficulty with anesthesia? ☐ Yes ☐ No
*IF Yes - Please explain/describe*

10 Have you had any bleeding tendencies? ☐ Yes ☐ No
*IF Yes - Please explain/describe*

revised 7/1/2009, © Joint Implant Surgeons, Inc.

11 Have any of your primary **FAMILY members (mother, father, brother, sister)** had the following? **NOT yourself - your family member**

| | | |
|---|---|---|
| Complications from Surgery | ☐ Yes | ☐ No |
| Problems with Anesthesia | ☐ Yes | ☐ No |
| Heart Disease before the age of 60 | ☐ Yes | ☐ No |
| Heart Attack or Chest Pain before the age of 60 | ☐ Yes | ☐ No |
| Hypertension | ☐ Yes | ☐ No |
| Blood Clots | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Bleeding tendencies | ☐ Yes | ☐ No |

If you answered yes to any questions in number 11 please explain:

______________________________________________

______________________________________________

12 Do you smoke or have you been a smoker in the past? ☐ Yes ☐ No

If yes, year you started smoking __________, if you quit smoking, year you quit____________

If yes on average, how many packs per day? _____________

Do you use other forms of tobacco?

☐ No ☐ Cigar ☐ Quit

☐ Pipe ☐ Chew

13 Do you drink alcohol ? ☐ Yes ☐ No

*IF Yes - Please complete the following*

number drinks per day ________________ *or* number drinks per week __________________

number years of alcohol use _________

Any medical complications from alcohol or withdrawal symptoms (please explain).

______________________________________________

14 Review of systems. Do you have any personal history of any of the following?

| | | |
|---|---|---|
| ☐ Yes | ☐ No | History of Cataracts |
| ☐ Yes | ☐ No | History of Glaucoma |
| ☐ Yes | ☐ No | Hearing Loss |
| ☐ Yes | ☐ No | Wear Dentures |

| | | |
|---|---|---|
| ☐ Yes | ☐ No | High Blood Pressure |
| ☐ Yes | ☐ No | Heart Attack |
| ☐ Yes | ☐ No | Congestive Heart Failure |
| ☐ Yes | ☐ No | Chest Pain with activity |
| ☐ Yes | ☐ No | Leg Swelling |
| ☐ Yes | ☐ No | Muscular Pain/Cramping when Walking, or poor circulation |

***Review of Systems continued…***

- ☐ Yes ☐ No Heart Murmur
- ☐ Yes ☐ No Heart Rhythm Disturbance or Palpitation

**Heart Tests:**

- ☐ Yes ☐ No Cardiac stress test
- ☐ Yes ☐ No Heart Catheterization
- ☐ Yes ☐ No Echocardiogram

If Yes to any test, please list year and where it was done

______________________________________________

- ☐ Yes ☐ No Asthma, COPD, Emphysema, or Chronic Bronchitis
- ☐ Yes ☐ No Shortness of Breath with mild activity
- ☐ Yes ☐ No Need to Sleep Propped up on 2 or more Pillows
- ☐ Yes ☐ No Frequent night time awakening due to Shortness of Breath
- ☐ Yes ☐ No Sleep Apnea
- ☐ Yes ☐ No TB Positive Skin Test

- ☐ Yes ☐ No Frequent Diarrhea
- ☐ Yes ☐ No Frequent Constipation
- ☐ Yes ☐ No History of Peptic Ulcers or Intestinal Bleeding
- ☐ Yes ☐ No Frequent Heartburn or Reflux
- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No History of severe postoperative constipation / ileus

- ☐ Yes ☐ No Urinary Difficulties or loss of Continence
- ☐ Yes ☐ No Frequent Urinary Tract Infections
- ☐ Yes ☐ No Prostate Enlargement
- ☐ Yes ☐ No Have you ever had problems with passing of a catheter into your bladder or had problems with urination after surgery?
- ☐ Yes ☐ No Is there any possibility that you are pregnant or have been pregnant in the past 3 months?

- ☐ Yes ☐ No Current Open Wounds
- ☐ Yes ☐ No Pressure Ulcers/Bed Sores

- ☐ Yes ☐ No Strokes, Mini Stroke, TIA, Paralysis
- ☐ Yes ☐ No Temporary loss of sensation, strength in arms or legs, slurring of speech
- ☐ Yes ☐ No Fainting Spells or Dizziness, Seizure
- ☐ Yes ☐ No Confusion or Disorientation

- ☐ Yes ☐ No Anxiety or Nervousness for Which You've Been Treated
- ☐ Yes ☐ No Depression for which you have been treated
- ☐ Yes ☐ No Diabetes

***Review of Systems continued…***

☐ Yes ☐ No Thyroid problems
☐ Yes ☐ No Excessive surgical bleeding, bruising or nose bleeds
☐ Yes ☐ No History of Blood Clots / Phlebitis
☐ Yes ☐ No History of Hernia
☐ Yes ☐ No Unusual or frequent Infections
☐ Yes ☐ No Poor wound healing

If you have answered yes to any of these questions please explain:

___________________________________________

___________________________________________

15 Do you have a history of TB ☐ Yes ☐ No
Have you been exposed to TB ☐ Yes ☐ No
Date of exposure ______________
History of TB Skin Test ☐ Yes ☐ No
☐ positive ☐ negative
Date of Skin Test (approx.) ______________

Last vaccinations (if known) :

| | | | Date | | | | Date |
|---|---|---|---|---|---|---|---|
| Influenza (flu) | ☐ No | ☐ Yes | ________ | Hepatitis | ☐ No | ☐ Yes | ________ |
| Tetanus | ☐ No | ☐ Yes | ________ | Pneumonia | ☐ No | ☐ Yes | ________ |

Other ___________________________________________

Do you have any recent history of the following (check any that apply):
☐ No problems
☐ Productive cough ☐ Lethargy / Weakness ☐ Night Sweats
☐ Coughing up blood ☐ Fever ☐ Loss of Appetite

16 Do you use street/recreational drugs ☐ Yes ☐ No ☐ In a Recovery Program
What kind? ___________________________________________
Date last used: ___________________________________________

17 Do you have any problems with (check all that apply) ☐ No problems
☐ Taste ☐ Touch ☐ Smell

Do you have any problems with your vision? ☐ Yes ☐ No
Vision Aids used: ☐ Glasses ☐ Contacts

Do you have any problems with your hearing? ☐ Yes ☐ No
Hearing aids used: ______________________________

 © Joint Implant Surgeons, Inc. 

# Patient History



18 Do you have any special diet, food or cultural preferences / requirements? (check all that apply)

☐ no preferences

☐ Regular ☐ Low Salt

☐ Soft ☐ Low Cholesterol

☐ Kosher ☐ Vegetarian

☐ Diabetic *Please identify specific calorie count if used* ____________

☐ Other ____________

Describe your appetite ☐ Good ☐ Fair ☐ Poor

Have you had a recent weight change: ☐ Yes ☐ No

If you answered yes, was the change a: ☐ Gain ☐ Loss

how many pounds ____________

Do you have any difficulty or special needs with passing urine or stool? ☐ Yes ☐ No

☐ Urinary Catheter ☐ On Dialysis

☐ Colostomy ☐ Ileostomy

---

Form Completed by ____________ Date ____________

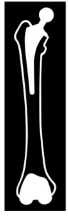
If other than the patient, please identify the relationship ____________

Reviewed by ____________ Title ________ Date ____________

Please use a separate sheet of paper if you need more space

**IMPORTANT: Please bring either a list of medications including dosage and frequency or actual pill bottles. (include herbal supplements, vitamins and over the counter medications)**

revised 7/1/2009, © Joint Implant Surgeons, Inc.



JOINT
IMPLANT
SURGEONS,
INC.

7277 Smith's Mill Road, Suite 200
New Albany, OH  43054
(614) 221-6331 – Main
(614) 242-1068 – Billing Dept.

# Billing Information

The Billing Department at Joint Implant Surgeons, Inc. will be happy to file all health insurance claims for you, to both your primary and secondary carriers. To accomplish this successfully, we need your help in the following ways:

**Insurance Information:** Our receptionist will need to copy your ***current*** insurance cards and your driver's license at your first appointment. Insurance cards will need to be copied any time there has been a change in coverage, or policy numbers. It is your responsibility to keep our office informed of your correct, current insurance information.

**Referrals:** If your insurance requires you to have a referral from your Primary Care Physician, it is ***your*** responsibility to make sure a current referral is on file in our office each time you are seen. Failure to have a current referral will result in a reduction in benefits paid by your carrier and more out of pocket cost for you.

**BWC:** If you are covered under an ***active*** Bureau of Workers' Compensation Claim, it is your responsibility to make sure you have authorization from your managed care organization (MCO) for each visit. Failure to have authorization may result in a denial of payment from your MCO, leaving ***you*** responsible for payment.

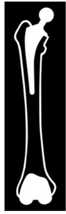
**Co-pays:** Co-pays are part of your signed contract with your insurance company and will be collected upon checking in at the front desk. A co-payment is required at each office visit. Failure to pay your co-payment will result in a $20.00 processing fee which will be applied to your account.

**Medicare:** We do not participate in Medicare HMO plans. Please call our Billing Department at (614) 242-1068 if you have questions regarding your coverage.

**Medicaid:** If you are a recipient of Medicaid from the State of Ohio, you must bring your ***current*** month's card with you to all office visits.

**No Insurance / Motor Vehicle Accidents:** If you have no billable health insurance, or if you have been involved in a motor vehicle accident, you will be required to pay in full at the time of service. Please call us if you have any questions.

Thank you for your cooperation.



JOINT
IMPLANT
SURGEONS,
INC.

7277 Smith's Mill Road, Suite 200
New Albany, OH 43054
(614) 221-6331 – Main
(614) 242-1068 – Billing Dept.

# Medicare/Medigap Lifetime Authorization

Patient/Beneficiary ______________________ HIC Number ______________________

I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine those benefits payable for related services.

I request that payment of authorized medical benefits be made to: Joint Implant Surgeons, Inc. on my behalf for any services furnished by that Physician/ Provider.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA 1500 claim form is completed, my signature authorizes releasing of needed information to my Medigap carrier. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

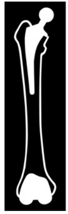
Beneficiary/Patient Signature ______________________ Date ______________________

# Release Form for Non-Covered Services

Insurance regulations now suggest that we inform you in advance if we believe certain services / supplies, such as durable medical equipment, may not be covered by your insurance carrier. Although this implies that such services and/or supplies may not be medically necessary, in our professional judgment these services/supplies are needed in order to render the highest quality of care to you.

By signing this statement, you are agreeing to pay for the services/supplies, even if your insurance carrier determines that, according to their guidelines, the services / supplies are not covered.

Patient's Signature ______________________ Date ______________________




7277 Smith's Mill Road, Suite 200
New Albany, OH 43054
(614) 221-6331 – Main
(614) 242-1068 – Billing Dept.

# Prior Records Release

If you have had previous joint replacement surgery performed by surgeons other than Joint Implant Surgeons, Inc., we would like to have that surgical operative report when you come to your new patient consultation. Please complete this form and take it to your previous surgeon's office. The surgical report can be released to you and brought to your appointment with us, or faxed directly to our office.

I authorize ____________________________________ to release my operative report records to:

Attention: New Patients
Joint Implant Surgeons, Inc.
7277 Smith's Mill Road, Suite 200
New Albany, OH 43054
Fax: (614) 221-6301

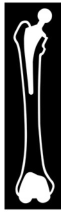
Patient's Name: ____________________________________________________

Patient's Date of Birth: ______________________________________________

Patient's Social Security No.: __________________________________________

Patient's Signature: _________________________________________________

Date: ____________________________________________________________



# Joint Implant Surgeons, Inc.

7277 Smith's Mill Road, Suite 200, New Albany, OH 43054
(614) 221-6331 • Fax: (614) 221-6301

**Please review and sign Acknowledgment Page prior to your appointment**

## Privacy Notice

**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.**

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. Your "protected health information" means any written or oral information about you, including demographic data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health or condition.

### Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

We may use your protected health information for the purposes of providing treatment, obtaining payment for treatment, and conduction health care operations. Your protected health information may be used or disclosed only for these purposes unless we have obtained your authorization or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. **Treatment**. We will use and disclose your protected healthcare information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:
   a. We may disclose your protected health information to a laboratory to order tests.
   b. We may disclose your protected health information to other physicians who may be treating you or consulting with us regarding your care.
   c. We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative, extended care or rehabilitation facilities, home care and physical therapy providers.
2. **Payment**. We will use your protected health information to obtain payment for the services we provide to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:
   a. We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.
   b. We may disclose your protected health information to anesthesia care providers involved in your care so they can obtain payment for their services.
3. **Health Care Operations**. We may use and disclose your protected health information to facilitate our own health care operations and to provide quality care to all of our patients. Health care operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your protected health information for health care operations:
   a. We may use your protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you.
   b. We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
   c. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.

d. We may also use or disclose your protected health information in the course of maintenance and management of our electronic health information systems.

4. **Other Uses and Disclosures**. As part of the functions above, we may use or disclose your protected health information to provide you with appointment reminders, to inform you of treatment alternatives, or to provide you with information about other health-related benefits and services which may be of interest to you.

### Uses and Disclosures of Protected Health Information Permitted without Authorization Required or Opportunity for the Individual to Object

The Federal privacy rules allow us to use or disclose your protected health information without your authorization and without your having the opportunity to object to such use or disclosure in certain circumstances, including:

1. **When Required By Law**. We will disclose your protected health information when we are required to do so by federal, state, or local law.
2. **For Public Health Reasons**. We may disclose your protected health information as permitted or required by law for the following public health reasons:
   a. For the prevention, control, or reporting of disease, injury or disability;
   b. For the reporting of vital events such as birth or death;
   c. For public health surveillance, investigations, or interventions;
   d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:
      - Collection and reporting of adverse events, product defects or problems, or biological product deviations
      - Tracking of FDA-regulated products
      - Product recalls, repairs, or lookback,
      - Post-marketing surveillance

   e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
   f. Under certain limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce.
3. **To Report Abuse, Neglect, or Domestic Violence**. We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.
4. **For Health Oversight Activities**. We may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.
5. **For Judicial or Administrative Proceedings**. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court of administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.
6. **For Law Enforcement Purposes**. We may disclose your protected health information to a law enforcement official for law enforcement purposes, including:
   a. Wound or physical injury reporting, as required by law.
   b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
   c. Identification or location of a suspect, fugitive, material witness, or missing person.
   d. Under certain limited circumstances when you are the victim of a crime.
   e. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.
   f. Reporting criminal conduct that occurred on the premises of the provider.
   g. In an emergency to report a crime.
7. **To Coroners, Medical Examiners, and Funeral Directors**. We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. In some cases such disclosures may occur prior to, and in reasonable anticipation of, the individual's death.
8. **For Organ or Tissue Donation**. We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplant.
9. **For Research Purposes**. We may use or disclose your protected health information for research

purposes when an institutional review board that has reviewed the research proposal and protocols to safeguard the privacy of your protected health information has approved such use or disclosure.

10. **To Avert a Serious Threat to Health or Safety**. We may, consistent with applicable law and standards of ethical conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public.
11. **For Specialized Government Functions**. We may use or disclose your protected health information, as authorized or required by law, to facilitate specified government functions related to military and veterans activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.
12. **For Workers' Compensation**. We may use and disclose your protected heath information, as necessary, to comply with workers' compensation laws or similar programs.

## Uses and Disclosures of Protected Health Information Permitted without Authorization Required but with an Opportunity for the Individual to Object

We may use your protected health information to maintain a directory of patients in our facility. The information included in the directory will be limited to your name, your location in our facility, and your condition described in general terms.

We may disclose your protected health information to a friend or family member who is involved in your medical care or payment for care. In addition, if applicable, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgment that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

## Uses and Disclosures of Protected Health Information which You Authorize

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. Authorizations are for specific uses of your protected health information, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

## Your Rights Regarding Your Protected Health Information

You have the following rights regarding your protected health information:

1. **The Right to Request Restriction of Uses and Disclosures**. You have the right to request that we not use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your protected health information to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies.

   We are not required to agree to a restriction you may request. We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your protected health information in violation of the agreed upon restriction, unless necessary for the provision of emergency treatment.

   We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to protected health information created or received by us after you receive the notice of termination of the restriction.

   Request for restrictions must be made in writing to the Privacy Officer.
2. **The Right to Request Confidential Communications**. You have the right to request that you receive communications of protected health information from us by alternative means or at alternative locations. We must accommodate reasonable request of this nature. We may condition the provision of accommodation by requesting information from you describing how payment will be handled, or by requesting specification of an alternative address or alternative form of contact. Requests for confidential communications must be made in writing to the Privacy Officer.
3. **The Right to Inspect and Copy Protected Health Information**. You have the right to inspect and obtain a copy of your protected health information that is maintained in a designated record set for as long as we maintain the protected health information. The designated record set is a collection of records maintained by us, which contains medical and billing

information used in the course of your care, and any other information used to make decisions about you.

By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and protected health information which is subject to a law which prohibits access to protected health information. Depending on the circumstance of your request, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You have a right to request a review of a denial of access.

If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing to the Privacy Officer.

4. **The Right to Amend Protected Health Information**. You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases we may deny your request. If we deny your request you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement and if we do so we will provide a copy of our rebuttal to you. Requests for amendment of protected health information must be made in writing to the Privacy Officer, and must include a reason to support the requested amendments.
5. **The Right to Receive an Accounting of Disclosures of Protected Health Information**. You have the right to request an accounting of disclosures of your protected health information made by us. This right applies to disclosures made by us except for disclosures: to carry out treatment, payment, or health care operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; for our directory, or other notification purposes, or to persons involved in your care; or for certain other disclosures we are permitted to make without your authorization.

   Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 14, 2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting request will be subject to a reasonable cost-based fee.
6. **The Right to Obtain a Paper Copy of this Notice**. Upon request, we will provide a paper copy of this notice.

## Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

## Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer.

**You will not be penalized for filing a complaint**.

## Contact Information

If you have privacy issues, if you believe that your privacy rights have been violated, or for further information about this Notice, please contact:

Privacy Officer and Contact
Joint Implant Surgeons, Inc.
7277 Smith's Mill Road, Suite 200
New Albany, Ohio 43054

The Privacy Officer and Contact can be contacted by telephone at (614) 221-6331

## Effective Date

This Notice is effective April 14, 2003.

**JOINT IMPLANT SURGEONS, INC.**
7277 Smith's Mill Road, Suite 200, New Albany, OH 43054
(614) 221-6331 • Fax: (614) 221-6301

## Privacy Notice Acknowledgement

I acknowledge that I have received a copy of the Privacy Notice for Joint Implant Surgeons, Inc.

Privacy Notice Revision Date: April 14, 2003

______________________________ ______________________________
**Patient or Personal Representative Signature** **Date**

______________________________
**Personal Representative's Relation to Patient**

**ABOVE - Patient or Personal Representative Use Only**

**BELOW - Provider Use Only**

## Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- ☐ Patient refused to sign the Privacy Notice Acknowledgement
- ☐ Patient was unable to sign because:

______________________________

______________________________

There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

- ☐ Other reason, described below:

______________________________

______________________________

______________________________ ______________________________
**Employee Signature** **Date**