UB|MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Visit Checklist

This checklist can help you prepare for your upcoming appointment. Please bring the following with you:

☐ **Completed Forms**. Prior to each appointment, be sure to check your email inbox for a message from our office requesting completion of important medical health forms from OBERD. Please complete all of the forms in their entirety prior to your appointment as this will save you time the day of your visit. If you are not able to complete the forms prior to your appointment, a member of the staff will ask you to complete the forms electronically on an IPAD at the start of your visit.

☐ **A valid Photo ID for each patient or patient's guardian.** If the patient is under the age of 18, they must be accompanied by a parent or guardian.

☐ **Your Insurance Card.** Please contact your insurance company to verify if a referral from your Primary Care Physician is needed. If a referral is needed, please contact your primary care physician for the referral, prior to your appointment. **Please note if your insurance information and/or referral are not in place by the time of your appointment, your appointment will be rescheduled*.

☐ **Workers' Compensation/No Fault.** If you were injured at work or in a motor vehicle accident, please bring the following information:

- **Claim #**
- **Insurance carrier name, address, phone & fax number**
- **Date of Injury/Accident**

**Please note: If you are unable to provide us with this information or your claim is not yet in process, you will be responsible for the payment of your office visit until the information is presented to us. Also, we recommend that you have a back-up referral in place with your personal health insurance carrier to help you cover any costs that may be denied by the Workers' Compensation, No-fault or third party liability carrier.*

☐ **Co-pay/Payment.** To be in compliance with federal regulations, we are required to collect your co-payment and or deductible, should you have one, at each office visit. If you have a High Deductible insurance plan, you will be required to pay a deposit prior to services being rendered. Co-pays/deposits may be paid by credit card. As of 08/01/2023 we will no longer be accepting cash or checks.

☐ If you had an X-ray, MRI, CT or Bone Scan done at an outside facility, please be sure to **bring all CD's and/or actual films of the images**, as well as any other studies or medical reports pertinent to your condition. Review of this information is a necessary part of your evaluation, even if the results were normal.

☐ **Shorts/Tank Top.** We recommend that you bring shorts, if we are seeing you a lower body injury, or a tank top, if we are seeing you for an upper body injury.

☐ **Policies.** Please visit our website at ubortho.com/patient-forms for our financial policy, privacy policy and general office policies.

☐ **Your Questions.** To make the most of your appointment, be sure to ask your doctor any questions or express any concerns you have.

UBMD Orthopaedics & Sports Medicine Outcomes Program

OBERD keeps you connected with your physician, and helps your physician assess your pain-level, mobility, and quality of life.

Our orthopaedic practice's goal is to make an improvement in your health and wellbeing. We study PROM's, or patient reported outcome measures because they're a remarkably sophisticated measure of not just whether a patient feels better, but how much better they feel.

Outcome measures study changes in a person's state of health after a period of treatment. Patient reported outcomes are exactly what they sound like: updated reports from you, the patient. We gather data on things like pain level, mobility, the ability to do daily tasks, activity levels, and much more.

At many points along your care path, this information is collected, added to our database, and reviewed by your care team. Ideally, it would track improvement in symptoms or a resolution of a problem by the end of your treatment with us. It is essential to fill out your questionnaires as accurately as possible.

Follow these simple steps to complete your forms:

- ☑ To receive text message reminders, provide us with your email address and cell phone number.
- ☑ Prior to your appointment, complete the questionnaire(s) sent to your email through a secured link.
- ☑ Sign in by entering your name, date of birth, and setting up security questions.
- ☑ Click EXIT when finished. You have no forms to print, save, or forget at home!
- ☑ Your answers are HIPAA-compliant, and are considered high patient confidentiality.

For additional questions or concerns, please email oberd@ubortho.com

UB MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Information - PEDIATRIC

Date: _____ Patient Legal Name: _____ Nickname: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Race: _____

Primary Language: _____ Ethnicity: ☐ Hispanic/Latino ☐ NOT Hispanic/Latino

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Parent's Email Address: _____

Pharmacy Name: _____ Pharmacy Address: _____ Pharmacy Phone #: _____

Mother's Name: _____ Mother's Date of Birth: _____

Mother's Address: _____ Cell Phone #: _____ Marital Status: _____

Mother's Employer: _____ Employer Address: _____ Employer Phone: _____

Father's Name: _____ Father's Date of Birth: _____

Father's Address: _____ Cell Phone #: _____ Marital Status: _____

Father's Employer: _____ Employer Address: _____ Employer Phone: _____

If parents are divorced or separated, who has: **FINANCIAL RESPONSIBILITY:** ☐ Mother ☐ Father ☐ Other _____
LEGAL CUSTODY: ☐ Mother ☐ Father ☐ Foster ☐ Other _____

If other: Responsible Party/Guarantor: _____ Date of Birth: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Address: _____ Phone #: _____

Primary Care Physician: _____ Address: _____ Phone #: _____

Date of patient's last office appointment with primary care physician: _____

Name of **Primary** Insurance Company: _____ Identification #: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Subscriber Phone #: _____ Subscriber Address: _____

Relationship to Patient: _____ Subscriber Employer: _____ Employer Phone #: _____

Name of **Secondary** Insurance Company: _____ Identification #: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Subscriber Phone #: _____ Subscriber Address: _____

Relationship to Patient: _____ Subscriber Employer: _____ Employer Phone #: _____

Is this visit related to an automobile or work accident? ☐ No ☐ Yes If yes, please indicate: ☐ Auto ☐ Work

If related to an automobile or work accident, please complete the No Fault/Workers' Compensation Form

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information. x _____ Date: _____

Signature of Patient or Parent/Legal Guardian (if patient is under 18 years of age)

UB MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical History – Pediatric

Last Name:_____First Name: _____MI: _____Today's Date: _____

DOB:_____Age:_____Height: _____Weight: _____Blood Type: _____

PRESENTING PROBLEM

Why is the patient seeing the doctor today?

Shoulder ☐Right ☐ Left **Elbow** ☐Right ☐ Left **Wrist** ☐Right ☐ Left **Hand** ☐Right ☐ Left **Arm** ☐Right ☐ Left

Hip ☐Right ☐ Left **Knee** ☐Right ☐ Left **Ankle** ☐Right ☐ Left **Foot** ☐Right ☐ Left **Leg** ☐Right ☐ Left

Neck ☐ **Back/Spine** ☐

My injury is: ☐ Sports Injury from ___/___/_____ ☐ Due to a Car Accident from: __/___/_____☐ Work Related from: __/_____/_____

☐ Other Injury from: _____/___/_____☐ No Known Specific Injury/Onset was: ☐Gradual ☐Sudden

*Please specify how the patient's injury occurred:*_____

_____

Has the patient had any diagnostic x-rays/scans/other tests done at a facility outside of UBMD Orthopaedics?: ☐ No ☐ Yes

If YES: What test(s) was performed?: _____What date?: _____

Were tests done at John R. Oishei Children's Hospital?: ☐ Yes ☐ No – If no, what facility? _____

Birth weight: _____ ☐ Gestational Age: _____ or ☐ Full Term

Mother's Health During pregnancy: ☐ Good/Normal ☐ Problems: _____

Child's Health after Delivery: ☐ Good/Normal ☐ Problems: _____ Admission to NNICU Duration:_____

Developmental Milestones: *Please enter the age when child did the following on their own*

Sat Up_____Crawled _____Stood_____Walked_____Spoke words_____Spoke sentences_____

Present Function: ☐ Walking independently ☐ Walking with assistance ☐ Sitting independently ☐ Cruises ☐ Tall kneels ☐ Uses both hands

Assistive Devices: ☐ Stroller ☐ Wheelchair ☐ Cane ☐ Crutches ☐ Walker ☐ Other:_____

Braces: ☐ AFO(s) ☐ Other: _____

Therapy/Manipulations:

☐ Physical Therapy: Where - _____When -_____How Often - _____

☐ Occupational Therapy: Where - _____When -_____How Often - _____

☐ Chiropractic: Where - _____When -_____How Often - _____

ALLERGIES: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Nickel ☐ Cobalt ☐ Chromate ☐ Latex ☐ Iodine ☐ Pollen

☐Other Allergies Not Listed:_____

MEDICATIONS: ☐ None

List medications (*including over the counter medications, such as vitamins, Tylenol, etc.)* Please provide a typed medication list if necessary.

Drug	Dosage	How Taken *(with meals, as needed, etc)*	Reason

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REVISED 11.12.2019

UB MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical History – Pediatric

PATIENT NAME:_____

PAST MEDICAL ILLNESS/INJURY/SURGERY: ☐None

List all Illness/Injuries/Surgeries	Date	Treating Physician	Hospital	Response

Has the patient ever had any surgical complications?: ☐No ☐Yes, please explain: _____

Has the patient ever had a blood transfusion?: ☐No ☐Yes, Date & Reason: _____

Have you received an influenza vaccine/flu shot within the past 12 months? ☐No ☐Yes - if yes, Date: _____

PAST / FAMILY MEDICAL HISTORY: *Check if any of these apply to the patient and/or anyone in the patient's family.*

	PATIENT	FAMILY		PATIENT	FAMILY		PATIENT	FAMILY
No Problems	☐	☐	Genetic Disease	☐	☐	Nerve Disorder	☐	☐
Anesthesia Complications	☐	☐	Immune System Disease	☐	☐	Scoliosis	☐	☐
Blood Disease	☐	☐	Malignant Hyperthermia	☐	☐	Tumors	☐	☐
Bone or Joint Disease	☐	☐	Muscle Disorder	☐	☐	Other:	☐	☐

Specify:_____

List Immediate Family members (mother, father, siblings) and their health as indicated:

Name	Relationship	Age	Good Health		Medical Condition(s)/Illness
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	

SOCIAL HISTORY

Who does patient live with?: _____

Does patient attend school?: ☐ No ☐ Yes – What grade?: _____

Work or Occupation: _____ Current Employer:_____

Exposure to smoke or use of tobacco: ☐ No ☐ Yes

Use of Alcohol: ☐ No ☐ Yes

Regular exercise: ☐ No ☐ Yes

Participate in Sports: ☐ No ☐ Yes – If yes, which sport (s)?: _____

DOCUMENT NO: FRM008.01-AK
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UB MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical History – Pediatric

PATIENT NAME:_____

REVIEW OF SYSTEMS

Please check any of the following health problems that apply to the patient.

GENERAL HEALTH
- ☐Excellent
- ☐Good
- ☐Fair
- ☐Poor

EYES
- ☐**No Problems**
- ☐Glasses/Contacts
- ☐Lazy Eye
- ☐Blurred Vision
- ☐Other:_____

EAR/NOSE/THROAT
- ☐**No Problems**
- ☐Hearing Loss or Ringing
- ☐Earaches
- ☐Nose Bleeds
- ☐Sinusitis
- ☐Hoarseness/Voice Change
- ☐Sore Throat/Difficulty Swallowing
- ☐Other: _____

SKIN PROBLEMS
- ☐**No Problems**
- ☐Birth Marks/Spots
- ☐Rash
- ☐Painful bumps on skin
- ☐Itching
- ☐Other: _____

CARDIOVASCULAR
- ☐**No Problems**
- ☐Chest Pain
- ☐Heart Murmurs
- ☐Blueness of Extremities/Lips
- ☐High Blood Pressure
- ☐Leg/Ankle Swelling
- ☐Irregular Heartbeat
- ☐Low Blood Pressure
- ☐Other:_____

RESPIRATORY
- ☐**No Problems**
- ☐Asthma
- ☐Pneumonia
- ☐Shortness of Breath
- ☐Chronic or Frequent Coughs
- ☐Other:_____

MUSCULOSKELETAL
- ☐**No Problems**
- ☐Joint Pain, stiffness, swelling
- ☐Weakness of muscles or joints
- ☐Muscle pain or cramps
- ☐Back Pain
- ☐Cold Extremities
- ☐Frequent Dislocations
- ☐Other: _____

GASTROINTESTINAL
- ☐**No Problems**
- ☐Loss of Appetite
- ☐Change in bowel movements
- ☐Nausea or Vomiting
- ☐Frequent Diarrhea
- ☐Abdominal pain
- ☐Constipation
- ☐Reflux
- ☐Ulcers
- ☐Other:_____

GYNECOLOGICAL
- ☐**No Problems**
- ☐Menstrual Periods:
  Age started: _____
- ☐Excessive Bleeding
- ☐ Menstruation Problems
- ☐Other:_____

GENITOURINARY
- ☐ **No Problems**
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐Kidney Stones
- ☐Urinary Tract Infections
- ☐Bed Wetting
- ☐Bloody Urine
- ☐Kidney Disease
- ☐Other: _____

ENDOCRINE
- ☐**No Problems**
- ☐Glandular/hormone problem
- ☐Thyroid Disease
- ☐Diabetes
- ☐Heat or Cold Intolerance
- ☐Excessive thirst or urination
- ☐Other:_____

NEUROLOGICAL
- ☐**No Problems**
- ☐Headaches
- ☐Seizures
- ☐Tremors
- ☐Stroke
- ☐Claustrophobia
- ☐Paralysis
- ☐Numbness or Tingling
- ☐Head Injury/Concussion
- ☐Other:_____

HEMATOLOGIC/LYMPHATIC
- ☐**No Problems**
- ☐Blood Clots
- ☐Anemia
- ☐Bleeding or bruising Tendency
- ☐Other:_____

PSYCHIATRIC
- ☐**No Problems**
- ☐Insomnia
- ☐Memory Loss/Confusion
- ☐Panic Attacks
- ☐Depression
- ☐Other:_____

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information.

_____ _____ Date:_____

Print Name of Patient or Parent/Legal Guardian (If patient is under 18 years of age)

Signature

DOCUMENT NO: FRM008.01-AK
REVISED 11.12.2019

UB MD ORTHOPAEDICS & SPORTS MEDICINE

No Fault/Workers' Compensation Form

☐Please check here if not applicable

Please complete if Auto (No Fault) or Work Accident (Workers' Compensation)

*Please note: if you are unable to provide us with this information, or your claim is not yet in process, you will be responsible for the payment of your office visit until the information is presented to us. Also, we recommend that you have a back-up referral in place with your personal health insurance carrier to help you cover any costs that may be denied by the Workers' Compensation, No-fault or third party liability carrier.

Patient Name: _____ Social Security #: _____

Date/Time of Accident/Injury: _____ Adjuster/Case Manager Name: _____

No Fault/Workers' Compensation Insurance Information

Name of Insurance Carrier: _____ Claim #/Carrier Case #/Policy #: _____

Insurance Carrier Address: _____ City: _____ State: _____ Zip: _____

Insurance Carrier Phone #: _____ Insurance Fax Phone #: _____

If No Fault/Auto Accident: Please complete the attached **Assignment of Benefits Form** on the reverse of this page.

Please complete the following **only if Workers' Compensation**:

WCB #: _____ Carrier W #: _____

Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Location injury occurred (if different from employer address): _____

Job Title at time of Injury: _____ Body Part(s) Injured: _____

Date Injury reported to your employer: _____

Description of how injury occurred: _____

_____

_____

Have you lost time from work due to this injury: ☐ No ☐ Yes If yes: what dates: _____

Have you had the same or similar injury prior to this accident: ☐ No ☐ Yes If yes: what dates: _____

Have you been treated by another doctor for this injury: ☐ No ☐ Yes If yes: by whom: _____

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information.

x _____ Date: _____

Signature of Patient or Parent/Legal Guardian (if patient is under 18 years of age)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: _____

I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

UNIVERSITY ORTHOPAEDIC SERVICES, INC.
_____ _____
(Print name of Provider) **(Signature of Provider)**

_____ _____
(Date of signature)

BUFFALO, NY 14240

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

UBMD ORTHOPAEDICS & SPORTS MEDICINE

Release of Information

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Last Name: _____ First Name: _____

Previous Name: _____ Date of Birth: _____

☐ I authorize and request healthcare information for the abovementioned patient be released to UBMD Orthopaedics & Sports Medicine

☐ I authorize and request UBMD Orthopaedics & Sports Medicine to release healthcare information for the abovementioned patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Parent/Legal Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED

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UB|MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Financial Policy

University Orthopaedic Services, Inc. (d/b/a UBMD Orthopaedics & Sports Medicine) is dedicated to providing the best possible care for you. We offer the following information to help you understand our financial policy and aid you in planning for payment.

Insurance Verification and Co-payments

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due and payable at the time of service. All payments are expected to be made in U.S. dollars. UBMD Orthopaedics accepts cash, personal check, VISA, MasterCard, American Express, and Discover. There is a service charge of $25.00 for returned checks. Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. Unpaid accounts, including payment arrangements not made, will be turned over to a collection agency.

Insurance Plan Participation - subject to change, please visit our website at www.ubortho.com

UBMD Orthopaedics participates with the following insurance companies: Blue Cross Blue Shield, Independent Health, NYS Workers Compensation, Medicare & Railroad Medicare, Univera Healthcare, Empire Plan, Fidelis, Nova, United Healthcare, Aetna/Magnacare, Group Health Incorporated (GHI), Tricare, POMCO/Magnacare, YourCare, Fallon Health, NYS Medicaid.

It is the patient's responsibility to be aware of their insurance coverage, policy provisions and authorization requirements. Not all UBMD Orthopaedics providers participate with all insurances listed above. Please verify whether the physician accepts your insurance coverage when scheduling an appointment. We bill non-participating insurance companies as a courtesy to you. Payment is expected prior to service. Outstanding balances are the responsibility of the patient.

Self-Pay Accounts

Self-pay accounts shall exist if a patient has no insurance coverage. Payment is expected at the time of service, unless prior arrangements have been made with the physician's office.

High Deductible Plans (Health Savings Accounts or Heath Reimbursement Accounts) - PLEASE SEE BELOW

If your insurance is a High Deductible Plan (ex. IHA iDirect, BCBS POS, Univera) you will be required to pay a deposit prior to services being rendered. The deposit will be applied to your total cost, you will be billed for the balance owed or issued a refund for an overpayment.

No-Fault/Workers Compensation

Patients are responsible for providing our office with all information required to properly submit charges, i.e. insurer, claim #, date of injury, etc. Without this information, the fees mandated by New York State will be charged to reflect our private fees and you will be responsible for payment. If you have
private insurance with which we participate and obtain any referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

Medicare

We are "participating physicians." This means that we must accept Medicare's allowed charge for services rendered. Medicare will pay 80 % of the approved amount. The patient is responsible for the remaining 20% plus any out of pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

Cancellation Fee

A fee of $35 may be charged for any appointments missed or not cancelled before 24 hours of the scheduled visit. It is the patient's responsibility to notify the physician's office when an appointment needs to be cancelled or rescheduled.

Disability/Assessment Evaluation/Verification of Treatment Forms: All forms requesting completion must have the following: completed patient statement section, signed and dated where indicated. **There is a $10.00 charge for each form completed. (PRE-PAID IN CASH ONLY).** We are unable to accept a check for this service. Any checks received will be returned along with the form. The form fee is charged at the discretion of each office. Please allow approximately seven business days for forms to be completed and mailed or faxed. Please include any special instruction on what to do with the form once completed.

DOCUMENT NO: POL003.01-AK
REVISED: 10.24.2018

Surgical Cancellation and Rescheduling: Should you need to cancel or reschedule your surgery, a minimum 2 week notice is required. Failure to provide the office with the required notice may result in a $200 cancellation/rescheduling fee. This fee will not be submitted to your insurance and will be your responsibility to pay in full prior to scheduling any future appointments with the office. This cancellation fee is charged at the discretion of the surgeon.

Custodial Parent Responsibilities

The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating Insurance, or nonparticipating insurance. The office does not get involved with divorce specifics, e.g., one parent pays 80% and the other 20%. It is the parents' obligation to work out an agreement themselves or through the court system.

Office Policy on High Deductible Plans

"High Deductible" insurance plans are becoming common place, now more than ever because of the Affordable Care Act. These plans require the patient to spend out of pocket money (anywhere from a few hundred to several thousand dollars) for medical care before the insurance company reimburses for services. This deductible starts again each year your plan renews

It is our policy to **collect the deductible amount (if not met), copayment or coinsurance at time of service in the office and prior to service for procedures and elective surgeries**. We base these fees on the fee schedule provided by the insurance companies. After the claim has processed, if there is a difference in the amount, a refund will be issued for overpayment or a bill will be sent for any additional amount owed.

Sometimes fees exceed what the patient anticipates having to pay when they schedule an appointment. For example, at an office visit you may end up having an x-ray, procedure (i.e.: fracture, injection), treated for a fracture, DME (durable medical equipment), etc., which all have legitimate fees that are subject to your deductible if not met. We cannot always anticipate all what will happen at your visit. Patients having concerns about fees for which they might be responsible are expected to ask before the services are rendered. We are happy to answer your questions.

It is ultimately the patient's responsibility to know if their plan has a "High Deductible" and if it has been met for the year. If you have any questions regarding your plan you should contact your insurance carrier for every plan is different.

If you have any additional questions or concerns regarding our office policy, please feel free to ask our staff.

UB MD ORTHOPAEDICS & SPORTS MEDICINE

General Information & Policies

Please take a few minutes to read the below information regarding general information and important policies. This information is provided to answer questions most frequently asked by patients.

New Patient Information Forms: At your first appointment, or if you have not been seen in the office within the last 12 months, you will be asked to complete a patient information packet. You may also be asked to complete additional forms should your information change over the course of the year. This information assists your physician in your care, therefore complete and accurate information is important.

Appointment Health Forms: Prior to each appointment, be sure to check your email inbox for a message from your physician's office requesting completion of important medical health forms from OBERD. If you are not able to complete the forms prior to your appointment, a member of the staff will ask you to complete the forms electronically on an IPAD at the start of your visit.

Appointments & Cancellations:

To schedule, reschedule or cancel an office appointment, you may call our office at **(716) 204-3200.**

- Please notify us as soon as possible in the event you need to reschedule or cancel your appointment.
- If you need to be seen immediately, we will do our best to accommodate you.
- Follow-up appointments should be made when you check out.
- Canceling an appointment: Cancellations should be made at least 24 hours prior to your scheduled appointment time. If you know you will not be able to keep your appointment, contact our office as soon as possible. **You may be charged a fee of $35.00 if you fail to show for your appointment**. If you cancel or fail to show for three consecutive appointments, we reserve the right not to reschedule your appointment and you may be dismissed from our practice.

Office Locations: We have several convenient locations to serve you. Your physician may practice at one or more of these locations. You will be asked at the time of scheduling your appointment which location you would like to be seen at.

Physician Assistants: There may be times during the course of your treatment when you may see a physician assistant. Our physician assistants are an integral part of our orthopaedic team and work directly under the supervision of your physician. If at any point you need to speak to the physician, please let a member of the staff know.

Checking-In: Upon checking-in for your appointment, you will be asked to verify all of your demographic and insurance information. The receptionists will request a copy of your valid photo ID and your insurance card. While we understand that your information may not have changed since your last appointment, we want to ensure the highest level of service by verifying such.

X-rays: We request that all new patients have x-rays taken to be reviewed at their initial appointment. X-rays are essential for proper diagnosis and evaluation. If the x-rays were taken at an outside location, we ask that you bring the cd and/or actual films with you to your appointment. We may also request that an established patient have repeat x-rays taken if (a) more than a year has passed since the last x-ray or (b) there is a new injury/aliment being reported.

Cell Phone Use: As a courtesy to others, we request that you turn off your cellular phone while in the office.

Telephone Calls & Medical Questions: We make every effort to answer calls as they come in but should we not be available, please leave a message and we will respond to all non-urgent calls within 24 hours. Except in emergencies, our physicians and physician assistants will not be able to accept calls while they are in clinic with patients. The team will respond to your call either between patients (time permitted), at the end of the clinic or the next business day.

Patient Portal: Start using our Patient Portal today! Using the patient portal will allow you to bypass voicemails and communicate with us at your convenience, 24/7. Through the patient portal, you can securely message with your physician's office, view and request appointments, review test results, update personal information, request prescription refill, pre-register for your visit. To get started, please call 716-204-3200 for your activation code.

Billing Questions: Should you have questions about billing, you can contact our billing office directly at 716-906-5990.

UB MD ORTHOPAEDICS & SPORTS MEDICINE

General Information & Policies

Medical Records: When requesting copies of your medical records, we ask that you please allow a minimum of ten to fourteen days to prepare your request. For your convenience, you may place your request by calling (716) 204-3200 during normal business hours. Please leave a message with the patient's name, spelling of the name, date of birth, contact phone # and specific records being requested. You can also request medical records via the patient portal.

Disability/Assessment Evaluation/ Verification of Treatment Forms: All forms requesting completion must have the following: completed patient statement section, signed and dated where indicated. **There is a $10.00 charge for each form completed. (PRE-PAID IN CASH ONLY).** We are unable to accept a check for this service. Any checks received will be returned along with the form. The form fee is charged at the discretion of each office. Please allow approximately 7 business days for forms to be completed and mailed or faxed. Please include any special instruction on what to do with the form once completed.

Prescriptions: All new prescriptions will be sent electronically to the pharmacy. If you need a refill on your prescription, please call our office at (716) 204-3200. Prescription requests made before 3:00 PM will be handled the same day. To facilitate efficient handling, please provide the following information at the time of the request:

- Your full name
- Your date of birth
- A number where you can be reached
- The name of the medication(s) you need refilled (including strength).
- The pharmacy you use (name and phone number)

We will contact you to inform you if your prescription will **not** be called in or if we have further questions, otherwise the prescriptions will be sent to your pharmacy and you can check with them after 6:00 PM. At times, a refill may not be given if a patient has not been seen within the last three months, therefore you may be asked to make an appointment prior to receiving your prescription.

Narcotic Pain Medication Policy:

- Narcotic pain medication will ONLY be prescribed for post-operative pain, or after an acute fracture.
- Narcotic pain medication will be closely monitored and **discontinued after 90 days**. If you feel that you require additional narcotic pain medication after this time frame, we can refer you to a pain management physician, or a physician specially trained in the treatment of chronic pain.
- For those receiving narcotic pain medication for one of the abovementioned situations, **refills will be closely monitored**.
    - Requests will NOT be filled early.
    - You must follow the directions on the bottle and not take medication more frequently than indicated.
    - It is the patient's responsibility to request refills in advance of running out of the prescription. Refills may take up to 48 hours to complete. Narcotic pain medication will NOT be filled on an urgent basis.
    - **Narcotic pain medication will NOT be filled after regular office hours or on weekends and holidays.**
- We will not prescribe narcotic medication if you are receiving it from another physician.

Surgery: If you should require surgery, in addition to verbal instruction, your physician's team will provide you with a surgery packet including instructions for pre- testing, day of surgery and post-surgery instructions. Every effort will be made to keep your surgery on schedule; however, we are dependent on the surgical facility to ensure that we have the equipment and staff available to perform your surgery. In rare cases, your surgery may need to be cancelled but you will be informed as to the reason of the cancellation, and your surgery will be rescheduled accordingly.

Surgical Cancellation and Rescheduling: Should you need to cancel or reschedule your surgery, a minimum 2 week notice is required. Failure to provide the office with the required notice may result in a $200 cancellation/rescheduling fee. This fee will not be submitted to your insurance and will be your responsibility to pay in full prior to scheduling any future appointments with the office. This cancellation fee is charged at the discretion of the surgeon.

Please see attached for our **Financial Policy** and **Privacy Policy.**

NOTICE OF PRIVACY PRACTICES
University Orthopaedic Services, Inc.

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.

EFFECTIVE DATE OF THIS NOTICE: April 14, 2003 **REVISED DATE OF THIS NOTICE: May 25, 2017**

I. University Orthopaedic Services, Inc. (PRACTICE PLAN} LEGAL OBLIGATIONS

We are required by law to maintain the privacy of your protected health information **(PHI).** This includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care for you, or the payment of this health care.

We are required by law to provide you with a Notice of Privacy Practices (NPP) which describes our legal duties and privacy practices with respect to PHI. This notice will tell you about the ways in which we may use and disclose PHI about you. It also describes your rights and our obligations regarding the use and disclosure of your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this NPP. We are required to post the NPP within our facility and website and we are required to abide by the terms of the NPP that is currently in effect.

Please note, however, that special privacy protections apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information and genetic information, which are not set forth in this notice. Uses and disclosures for these purposes reflect other more stringent, applicable laws. for more information please contact the person listed in Section 4. Contact, of this NPP.

We reserve the right to change the terms of the NPP and our privacy policies at any time. Any changes made will apply to the PHI we already have about you as well as any information we create or receive in the future. We will promptly post the revised NPP, with a new effective date. Upon your request, a copy of the revised NPP will be made available to you.

We will notify you promptly and in no case later than 60 days after the discovery of the breach that may have compromised the privacy or security of your PHI.

2. HOW Practice Plan MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION <PHI}

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations. The following categories describe different ways that we may use or disclose your PHI. Examples are provided where appropriate, although it is impossible to list every use and disclosure in each category.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with another physician. We will also disclose PHI to other physicians or health care professionals who may be treating you. For example, to a physician to whom you have been referred to ensure that he/she has the necessary information to diagnose or treat you.

Payment: We may use and disclose PHI about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose PHI to a health plan in order for the health plan to pay for the services rendered to you. We may also tell your health plan about a treatment or procedures you are going to receive in order to obtain prior approval or to determine whether your health plan will cover the services.

Health Care Operations: We may use and disclose PHI about you for Practice Plan operations. These uses and disclosures are necessary to run our Practice Plan in an efficient manner and ensure that all patients receive quality care. For example, your medical records and PHI may be used in the evaluation of health care services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing. We may also disclose PHI about you to medical students and residents for review and learning purposes.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. For example, we may provide a written or telephone reminder that your next appointment is coming up.

UBMD, of which Practice Plan is a member, shares an integrated electronic medical record so that your caregivers at various UBMD offices can provide you with high quality, coordinated care. Access to the integrated medical record is expressly restricted to those clinicians and staff involved in your care, or to those who need the information for payment or health care operations or other purposes as set forth in this Notice.

To the extent we are required to disclose your PHI to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations, we will have a written agreement to ensure that our business associates also protect the privacy of your PHI.

Other Uses and Disclosures that Require Your Prior Written Authorizations.
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described in this **NPP.** If you choose to sign an authorization to disclose your **PHI,** you may revoke such authorization in writing, at any time, except to the extent that action has been taken in reliance of the use or disclosure indicated in the authorization.

Other Uses and Disclosures Where You Have the opportunity to Agree or Object.
Disclosures to Family, Friends or Others (Individuals Involved in your Care or Payment of your Care): We may release PHI about you to a friend or family member who is involved in your medical care or the payment of your health care, unless you object in whole or part. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Uses and Disclosures that May Be Made Without Your Consent, Authorization or Opportunity to Object. We may use and disclose your PHI without your consent or authorization for the following reasons:

Required by Law: We will disclose PHI about you when required to do so by federal, state or local law and the use or disclosure complies with and is limited to the relevant requirements of such law.

For Public Health Activities: We will report information about births and deaths; to prevent or control various diseases; to report child abuse and neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease. All such disclosures will be made in accordance with the requirements of federal, state or local law.

About Victims of Abuse. Neglect or Domestic Violence: We may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence.

For Health Oversight Activities: We may disclose PHI about you to a health oversight agency for activities authorized by law. These health oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.

lawsuits and Disputes: We may disclose your PHI if we are subpoenaed or ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

For Law Enforcement Purposes: We may release your PHI if asked to do so by a law enforcement official for any of the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's consent; about a death we believe may be the result of criminal conduct; about criminal conduct that occurred on our property; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

For Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner when authorized by law. This may be necessary, for example, to determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

For Organ or Tissue Donation Purposes: If you are an organ donor, we may release PHI to organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

To Avert a Serious Threat to Health or Safety: ln order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

Specialized Government Functions: We may disclose PHI for national security purposes to authorized federal officials authorized by law. In addition, we may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign head of state or to conduct special investigations.

Military and Veterans Activities: If you are a members of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing PHI that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers· Compensation: We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Emergency Situations: We may use or disclose your PHI if you need emergency treatment and we are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Communication Barriers: We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with the patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs or on decedents. Under other limited circumstances, we will ask for your written authorization before using your PHI for research purposes.

Health-Related Benefits or Services: We may use or disclose PHI to give you information about treatment alternatives or other health care services or benefits we offer and/or provide or that may be of interest to you.

Marketing: We will not disclose your PHI for marketing purposes unless you give us permission.

Fundraising: We may use PHI to contact you in an effort raise funds for our Practice Plan and its operations. We may also disclose PHI to other foundations or business associates so that these foundations or business associates may contact you in raising money for our Practice Plan. We would only release information such as name, address and phone number, the dates you received treatment or services, outcomes, and the name of the health care professional who treated you. For all other fund raising activities, you have the opportunity to opt out of receiving any further fundraising communications. To opt out, please contact the person listed in Section 4. Contact, of this NPP.

De-identified Information: We may also disclose your PHI if it has been de-identified or if it is not possible for anyone to connect the information back to you.

Incidental Disclosure: While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during, or as an unavoidable result of our otherwise permissible uses and disclosures of your PHI. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

3. INDIVIDUAL RIGHTS

The Right to Request Restrictions on Certain Uses and Disclosures of PHI.
You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We will consider your request for restrictions, but we are not legally required to accept it. If we accept your request, we will comply with your request except in emergency situations. To request restrictions, you must make your request in writing to the contact person listed in Section 4. Contacts of this NPP. The request must include 1. what information you want to limit; 2. whether you want to limit our use, disclosure or both; and 3. to whom you want the limits to apply, for example, disclosures to your spouse.

The Right to Receive Confidential Communications of **PHI.**
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You do not have to state a reason for your request. We will accommodate all reasonable requests. Your request must be in writing and specify how or where you wish to be contacted. To make a request please contact the person listed in Section 4. Contact, in this NPP.

The Right to Restrict Disclosure of PHI When You Pay For a Service in Full.
If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

The Right to Inspect and Copy **PHI.**
You have the right to access (inspect and/or copy) medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes that are maintained in separate files.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the contact person listed in Section 4. Contact, in this NPP. We will respond to your request to inspect within 10 days. We will respond to your request to copy within 30 days. If you request a copy of the information electronically or on paper, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. In addition, instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as Jong as you agree to that and to any associated costs in advance. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial, explain your right to have the denial reviewed, and the process by which you may complain to Practice Plan or Secretary of the Department of Health and Human Services (See Section 5. Complaints, of this NPP). If you request that the denial be reviewed, another licensed health care professional chosen by Practice Plan will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will comply with the outcome of the review.

The Right to Amend PHI.
If you feel that medical information maintained about you is incorrect or incomplete, you may request that we amend the information. You have the right to request an amendment for as long as the information is kept by Practice Plan.

You must provide the request and your reason for the request in writing to the contact person listed in Section 4. Contact, in this **NPP.** We will ordinarily respond within 60 days of receiving your request. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and a date by which you will have a final answer to your request, which shall be no later than 90 days from the date of the original request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that 1. was not created by us, unless the person or entity that created the information is no longer available to make the amendment; 2. is not part of the medical information kept by or for Practice Plan; 3. is not part of the information which you would be permitted to inspect or copy; or 4. is accurate and complete. Our written denial will state the reasons for the denial, explain your right to file a written statement of disagreement with the denial, and the process by which you may complain to Practice Plan or Secretary of the Department of Health and Human Services (See Section 5. Complaints, of this NPP). This statement must be submitted in writing to the contact person listed in Section 4. Contact, of this NPP. If you do not file such a statement, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done so and tell others that need to know about the changes to your PHI.

The Right to Receive an Accounting of Disclosures of **PHI.**
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI, but will not include uses or disclosures that you have already been informed of in this NPP, such as those made for treatment. payment or health care operations, directly to you, or to your family or pursuant to a signed authorization. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or those made before April 14, 2003.

To request this list or accounting of disclosures, please submit your request in writing to the person listed in Section 4. Contact, of this NPP. Your request must state the time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will respond to your request within 60 days. The list you receive will include 1. date of the disclosure; 2. to whom the PHI was disclosed, including their address, if known; and 3. a brief description of the PHI disclosed and the reason for the disclosure.

The Right of an Individual to Receive a **Paper** Copy of this **NPP.**
You have the right to a paper copy of this NPP. You may ask us to give you a copy of this NPP at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this NPP, or if you have questions about this NPP or our privacy practices, please contact the person listed in Section 4. Contact.

4. CONTACT

University Orthopaedic Services, Inc.
Attn: Chief Compliance Officer
77 Goodell Street, Suite 310, Buffalo NY 14203
716-888-4705

5. COMPLAINTS

If you think your privacy rights have been violated or you disagree with a decision we made about access to your PHI, you may file a complaint with University Orthopaedic Services, Inc. by contacting the person listed above in Section 4. You may also send a written complaint to the Secretary of the Department of Health and Human Services at Office of the Secretary, Department of Health & Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

THIS DOCUMENT IS ALSO AVAILABLE IN **LARGER PRINT.**

1 Brook Bridge
5959 Big Tree Rd., Ste.a108
Orchard Park, NY 14127

2 Buffalo General Medical Center
100 High St.
Buffalo, NY 14203

3 Depew-Lancaster
5102 Transit Rd.
Depew, NY 14043

4 Canalside
100 Washington St.
Buffalo, NY 14203

5 Erie County Medical Center
462 Grider St.
Buffalo, NY 14215

6 Oishei Children's Hospital
818 Ellicott St.
Buffalo, NY 14203

7 Orchard Park
4180 Abbott Rd.
Orchard Park, NY 14127

8 Summit Healthplex
6934 Williams Rd., Suite 600
Niagara Falls, NY 14304

9 Williamsville
111 North Maplemere Rd.
Suite 100,
Williamsville, NY 14221

10 Wyoming County Community Health System
400 North Main St.
Warsaw, NY 14569

UB|MD ORTHOPAEDICS & SPORTS MEDICINE

Scan this QR code to view our locations on the web.