MARKBREITER ORTHOPAEDICS

Lance A. Markbreiter, M.D., F.A.C.S   Board Certified Orthopaedic Surgeon

Last Name: ______________________ First Name: ______________________ MI: ______

Address: ______________________________ City: ____________________

State: ____________ Zip Code: ____________ Social Security: ____________________

DOB: ____________________ Age: __________ Sex: M________ F________

Home #: ______________________ Cell#: ______________________

Where is pain now? ____

Mark the area on your body where you feel the sensations described below using:

Aching	Numbness	Pins & Needles	Burning	Stabbing
VVV	========	OOOOOO	XXXXXXX	////////

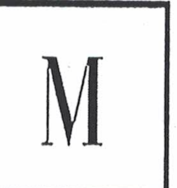
FRONT   BACK

RIGHT   LEFT   LEFT   RIGHT

Please mark with an X on the body form where the pain is worst now.

Please mark on the line below how bad your pain is now:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain imaginable)



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:__________ Initials:__________ Reason:______________________________

(not priv prac 4/11)

* Fellow of the American Board of Orthopaedic Surgeons

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