Today's Date: ________________________ Co-Pay: ______________

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

How did you learn about our practice? ________________________________

Patients Name: ________________________________
Last First Middle

Patients Home Address: ________________________________

City: ________________ State: ________ Zip: __________

SSN: ________________ Birth date: ____________ Age: ____________ Sex: M F

Home Phone: (_______) ________________ Cell Phone: (_______) ________________

Email address: ________________________________

Occupation: ________________ Employer: ________________

Employer's Address: ________________ City: ________________ State: ______ Zip: ________

Work Phone: (____) ____________ Ext: _______ Pharmacy Location: ________________

Race: ____________ Language: ____________ Ethnicity: Hispanic Non-Hispanic Decline to Answer

PLEASE PROVIDE THE RECEPTIONIST WITH CURRENT INSURANCE CARDS AND DRIVERS LICENSE

Primary Insurance Plan: ________________ **Secondary Insurance Plan**: ________________

Plan ID#: ________________ Plan ID#: ________________

Subscriber: ________________ DOB: ________ Subscriber: ________________ DOB: ________

FINANCIALLY RESPONSIBLE PARTY (SIGNER OF FINANCIAL POLICY IF NOT THE PATIENT)

Name: ________________________________ Relationship to Patient: ________________
Last First Middle

Home Address: ________________ City: ________________ State: ______ Zip: ________

Birthdate: ____________ Age: ______ SSN: ________________ Phone: (___) ________________

Employer: ________________ Address: ________________

City: ________________ State: ______ Zip: ____________ Work Phone: (____) ____________ Ext: _____

How did your injury occur? ________________________________

On what date did the injury occur? ____________ Where did it happen: ________________

Did your injury happen on the job? Yes No If yes, did you report the accident to your employer? Yes No

Primary/Family Physician: ________________ Drug Allergies: ________________

In case of emergency, contact: ________________ *Relationship:* ________________

Home Phone: (_____) ________________ *Work or Cell Phone:* (______) ________________

Signature of Patient or Responsible Party: ________________________________

PLEASE TURN THIS SHEET OVER AND COMPLETE THE FINANCIAL INFORMATION

Financial Policies

Thank you for choosing St. Charles Orthopaedic Surgery Associates, Inc. (SCOSA) for your orthopedic care. We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

Referrals If you have an HMO plan we are contracted with, you need a referral from your primary care physician authorizing this treatment. If we have not received the authorization prior to your arrival at the office you may use the telephone available to call your primary care physician to obtain it. If you are unable to obtain the referral for your visit, you may be rescheduled or required to fill out and sign our "Visit with No Referral" form which makes the patient financially responsible for all charges incurred at your visit.

Your Financial Responsibilities:

Our office will file insurance for all reimbursable services, to your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. We accept payment by cash, check, Visa, MasterCard and Discover.

Payments can be made electronically via our website, www.scosamd.com.

You will receive billing statement(s) from our office for account balances that are your responsibility, balance in full is due within 15 business days. If the patient portion of your account is not paid in a timely manner, collection efforts will be made. Any collection agency fees incurred to collect the patient portion of your account will be at your expense.

HMO, POS and PPO plans that SCOSA contracts with: If the services you receive are covered by the plan and you have provided any required referral and/or authorization, you are responsible for all applicable copays and deductibles, these are to be paid at the time of service. If the services you receive are not covered by the plan, payment in full is requested at the time of service.

Commercial Insurance or PPO's that SCOSA does NOT contract with: SCOSA will submit your claims to your carrier as a courtesy if all current and accurate information is provided. You will be billed for any remaining balance with the total amount due within 15 days of billing.

Medicare: You will be responsible for any portion of your deductible that is not paid or covered by your secondary. You will be responsible for any service not covered by Medicare. If you do not have secondary insurance you will be responsible for the 20% copay. SCOSA will submit Medicare and secondary claims. All patient balances remaining after Medicare and secondary payment will be billed to you and will be due within 15 days of billing by this office.

Medicaid: SCOSA physicians do not accept new patients with Missouri Medicaid.

Workers Compensation: If we have verified the claim with your workers comp carrier no payment is necessary. If we are not able to verify your claim payment in full is required at the time of service. It is your responsibility to report your work comp injury to your employer and to inform us that your injury is the result of a work comp injury.

No Insurance: Payment in full is required at the time of service. If you have financial hardships we will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request a copy of our SELF-PAY POLICY and an APPLICATION FOR SELF-PAY PATIENT DISCOUNT form.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copays and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to St. Charles Orthopaedic Surgery Associates, Inc. (SCOSA)

I authorize SCOSA to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

____ ____________________

Signature of Patient or Responsible Party **Date**

St. Charles Orthopaedic Surgery Associates, Inc.
Request for Disability Form Completion

Patient Name: ____ Birth Date:______/_____/________

Address: ____ City:________________ MO:________ Zip:__________

Home Phone:__________________ Work Phone: ________________ Treating Physician: ______________________

Last date worked or will work: _____________________ Return to work (or approximate) date:_________________

******COMPLETED DISABILITY FORMS CANNOT BE FAXED******

Please indicate how you would like your completed form returned to you:

The $20 per form fee must be paid before the form will be completed.

A. _________ Mailed to my home (the address above)
B. _________ Mailed to the insurance company authorized below
C. _________ I will pick the form up at the following location:
_____ St. Peters _____ Winghaven / O'Fallon

PLEASE ALLOW 5 BUSINESS DAYS FOR THE COMPLETION OF YOUR DISABILITY FORM.

Authorization for Release of Information

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization

1. I Authorize the Following Health information to be Used and/or Disclosed.

_X_ Office Notes Dates of Service From: ____________________ To:____________________________

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information.

*St. Charles Orthopaedic Surgery Associates, Inc*____

3. I Authorize the Following Organizations to **Receive** and/or Use My Health Information. (**Include address**)

____

____

4. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

_*Payment of Disability Benefits*____

5. My Right to Revoke This Authorization. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact St. Charles Orthopaedic Surgery Associates, Inc. at (636) 561-0871. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

6. Redisclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

7. Disclosure of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information. I understand that

__X___ No One __________________________________Will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information. Amount or nature of remuneration: _________________

8. Expiration of Authorization. This authorization will be effective until the following date or event: _*Completion of care for orthopedic injury*____

_____________________________ ______/___/____ ___________ Paid: Check Cash Charge

Patient Signature Date Staff Initial #______

SIGNATURE MEDICAL GROUP, INC. ("SIGNATURE")
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice describes the privacy practices of Signature. It applies to the health services you receive at Signature, including all Divisions within Signature. Signature will be referred to herein as "we" or "us." We will share your health information among ourselves to carry out our treatment, payment, and health care operations.

1. **Our Privacy Obligations**. The law requires us to maintain the privacy of certain health information called "Protected Health Information" ("***PHI***"). Protected Health Information is the information that you provide us or that we create or receive about your health care. The law also requires us to provide you with this Notice of our legal duties and privacy practices. When we use or disclose (share) your Protected Health Information, we are required to follow the terms of this Notice or other notice in effect at the time we use or share the PHI. Finally, the law provides you with certain rights described in this Notice. Furthermore, we are required to notify you following a breach of unsecured PHI.

2. **Ways We Can Use and Share Your PHI Without Your Written Permission (Authorization)**. In many situations, we can use and share your PHI for activities that are common in many hospitals and clinics. In certain other situations, which we will describe in Section 3 below, we must have your written permission (authorization) to use and/or share your PHI. We do not need any type of permission from you for the following uses and disclosures:

   a. **Uses and Disclosures for Treatment, Payment and Health Care Operations.** We may use and share your PHI to provide "Treatment," obtain "Payment" for your Treatment, and perform our "Health Care Operations." These three terms are defined as:

      i. **Treatment.** We use and share your PHI to provide care and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment options. We may tell you about other health-related benefits and services that might interest you. We may also share PHI with other doctors, nurses, and others involved in your care.

ii. **Payment.** We may use and share your PHI to receive payment for services that we provide to you. For example, we may share your PHI to request payment and receive payment from Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of some or all of your health care ("***Your Payor***") and to confirm that Your Payor will pay for health care. As another example, we may share your PHI with the person who you told us is primarily responsible for paying for your Treatment, such as your spouse or parent. However, if you pay for a service or health care 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 Payor. We will follow your request unless a law requires us to share that information.

iii. **Health Care Operations.** We may use and share your PHI for our health care operations, which include management, planning, and activities that improve the quality and lower the cost of the care that we deliver. For example, we may use PHI to review the quality and skill of our physicians, nurses, and other health care providers.

iv. **Business Associates**. In addition, we may share PHI with certain others who help us with our activities, including those we hire to perform services.

b. **Your Other Health Care Providers.** We may also share PHI with your doctor and other health care providers when they need it to provide Treatment to you, to obtain Payment for the care they give to you, to perform certain Health Care Operations, such as reviewing the quality and skill of health care professionals, or to review their actions in following the law.

c. **Disclosure to Relatives, Close Friends and Your Other Caregivers.** We may share your PHI with your family member/relative, a close personal friend, or another person who you identify if we: (1) first provide you with the chance to object to the disclosure and you do not object; (2) reasonably infer that you do not object to the disclosure; or (3) obtain your agreement to share your PHI with these individuals. If you are not present at the time we share your PHI, or you are not able to agree or disagree to our sharing your PHI because you are not capable or there is an emergency circumstance, we may use our professional judgment to decide that sharing the PHI is in your best interest. We may also use or share your PHI to notify (or assist in notifying) these individuals about your location and general condition.

d. **Public Health Activities.** We are required or are permitted by law to report PHI to certain government agencies and others. For example, we may share your PHI for the following:

i. to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;

ii. to report abuse or neglect to government authorities, including a social service or protective services agency, that are legally permitted to receive the reports;

iii. to report information about products and services to the U.S. Food and Drug Administration;

iv. to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;

v. to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and

vi. to prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.

e. **Health Oversight Activities.** We may share your PHI with a health oversight agency that oversees the health care system and ensures the rules of government health programs, such as Medicare or Medicaid, are being followed.

f. **Judicial and Administrative Proceedings.** We may share your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

g. **Law Enforcement Purposes.** We may share your PHI with the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a subpoena.

h. **Decedents.** We may share PHI with a coroner, medical examiner or funeral director as authorized by law. The personal representative of the decedent has the authority to exercise rights regarding the decedent’s health information such as authorizing certain uses and disclosures of the information. We may share your PHI with a family member who was involved in your care or payment for your care prior to death, unless such disclosure would be inconsistent with any prior expression you have communicated to us. Under federal law, PHI does not include individually identifiable health information regarding a person who has been deceased for more than 50 years.

i. **Organ and Tissue Procurement.** We may share your PHI with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

j. **Research.** We may use or share your PHI if the group that oversees our research, the Institutional Review Board/ Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to begin the research process.

k. **Workers' Compensation.** We may share your PHI as permitted by or required by state law relating to workers' compensation or other similar programs.

l. **Disaster Relief**. We may share your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

m. **School Immunization Requests.** We may share your PHI for purposes of school immunization requests if the school is required by law to have documentation of such immunization(s) for enrollment.

n. **Fundraising**. We may contact you to raise funds for Signature Medical Group, Inc. You may tell us you do not wish to be contacted for this purpose, and will agree to remove you from the list. To do so, please contact the Privacy Officer.

o. **As required by law.** We may use and share your PHI when required to do so by any other law not already referred to above.

3. Uses and Disclosures Requiring Your Written Permission (Authorization).

a. **Use or Disclosure with Your Permission (Authorization).** For any purpose other than the ones described above in Section 2, we may only use or share your PHI when you grant us your written permission (authorization). For example, you will need to give us your permission before we send your PHI to your life insurance company.

b. **Marketing.** We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials paid for by a third party. However, we may communicate with you face to face about products or services related to your treatment, case management, or care coordination, or alternative treatments, therapies, health care providers, or care settings. For example, we may not sell your PHI without your written authorization.

c. **Uses and Disclosures of Your Highly Confidential Information.** Federal and state law requires special privacy protections for certain highly confidential information about you ("***Highly Confidential Information***"), including: (1) any portion of your PHI that is kept in psychotherapy notes; (2) about mental health and developmental disabilities services; (3) about alcohol and drug abuse prevention, treatment and referral; (4) about HIV/AIDS testing, diagnosis or treatment; (5) about sexually transmitted disease(s); (6) about genetic testing; (7) about child abuse and neglect; (8) about domestic abuse of an adult with a disability; (9) about sexual assault; or (10) In Vitro Fertilization (IVF). Before we share your Highly

Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

4. <u>**Your Rights Regarding Your Protected Health Information**</u>.

a. **For Further Information; Complaints.** If you want more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our HIPAA Privacy Officer. You may also file written complaints with the Office for Civil Rights ("***OCR***") of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not take any action against you if you file a complaint with us or with the OCR.

b. **Right to Receive Confidential Communications.** You may ask us to send PHI to a different location than the address that you gave us, or in a special way, or to contact you at a different phone number. You will need to ask us in writing. For example, you may ask us to send a copy of your medical records to a different address than your home address. We will accept all reasonable requests.

c. **Right to Revoke Your Written Permission (Authorization).** You may change your mind about your authorization or any written permission regarding your PHI by giving or sending a written "revocation statement" to the Privacy Officer. The revocation will not apply to the extent that we have already taken action where we relied on your permission.

d. **Right to Inspect and Copy Your Health Information.** You may request copies (for a reasonable fee) and/or access to your medical record file, billing records, and other records. You have a right to a copy of your records, if part of a "designated record set" in electronic format, as reasonably available. You can review your medical records and/or ask for hard copies. Under limited circumstances, we may deny you access to a portion of your records. If you want to receive a copy of your records, you may obtain a record request form from Signature. Return the completed form to your Signature provider.

e. **Right to Amend Your Records.** You have the right to request that your PHI be corrected if you believe it contains a mistake or is missing information in medical record files used to make decisions about your Treatment and payment for your Treatment. If you want to amend your records, you must tell us the reason for the change in writing by completing the amendment request form you can obtain from the Privacy Officer or your provider. After which, you can return the completed form to the Privacy Officer. We may deny your request if: (1) it does not include a reason for the change; (2) the information you want to change was not created by Signature or is not part of the medical record kept by Signature; or (3) the information contained in the record is complete and accurate.

f. **Right to Receive an Accounting of Disclosures.** You may ask for an accounting of certain disclosures of your PHI made by us. These disclosures must have occurred before the time of your request, and we will not go back more than six (6) years before the date of your request. If you request an accounting more than once during a twelve (12) month period, we will charge you based on the rate sheet. Direct your request for an accounting to the Signature Privacy Officer.

g. **Right to Request Restrictions.** You have the right to ask us to restrict or limit the PHI we use or disclose about you for treatment, payment, or health care operations. With one exception, we are not required to agree to your request. If we do agree, we will comply unless the information is needed to provide emergency treatment. Your request for restrictions must be made in writing and submitted to the Signature Privacy Officer. We must grant your request to a restriction on disclosure of your PHI to a health plan if you have paid for the health care item in full out of pocket.

h. **Right to Receive a Copy of this Notice.** If you ask, you may obtain a copy of this Notice, even if you have agreed to receive the notice electronically.

5. Effective Date and Duration of This Notice

a. **Effective Date.** This Notice is effective as of July 1, 2015.

b. **Right to Change Terms of this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in common areas throughout our facility, and on our Internet site at www.signaturemedicalgroup.com. You also may obtain any new notice by contacting the Privacy Officer.

Questions or Concerns: Please contact the Privacy Officer with any concerns or for additional information:

Privacy Officer, Jeanne Cantalin
Signature Medical Group, Inc.
314-843-1445 Ext.127
jcantalin@signaturehealth.net
Or at:
1-844-257-7766
compliance@signaturehealth.net

SIGNATURE
MEDICAL GROUP
PHYSICIANS MAKING A DIFFERENCE

SIGNATURE MEDICAL GROUP, INC.

Acknowledgment of Receipt of
Notice of Privacy Practices
Effective July 1, 2015

Do you authorize us to release any information to any other person or persons (spouse, parent, friend, child)? **No information such as test results, appointment changes or billing questions can be given to any other person unless listed below**. List name and relation:

	Name	Relation to patient
1.	______________________________	______________________________
2.	______________________________	______________________________
3.	______________________________	______________________________

May we leave detailed messages regarding test results or other information on your voice mail? YES NO

If your disability insurance carrier requests information about you, either verbally or in writing may we provide requested information? YES NO

I hereby acknowledge that I have received copy of Signature Medical Group, Inc.'s Notice of Privacy Practices.

____ ____________________

Signature of patient or parent/legal guardian/legally responsible person Date

____

Description of relationship to the patient

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual/Representative refused to sign the form
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

Name of employee completing Form:____

Signature: ______________________________ Date: ____________________

St. Charles Orthopaedic Surgery Associates
Self-Pay Patient Policy

Policy: In order to make our services accessible to patients lacking health care coverage, St. Charles Orthopaedic Surgery Associates ("SCOSA") offers a significant discount for self pay patients. SCOSA will identify patients without insurance coverage and consistently apply a method of billing, discounting, and collecting from the uninsured in the community. Patients without insurance coverage are not required to apply for the self-pay discount in order to obtain treatment at St. Charles Orthopaedic Surgery Associates.

Procedure:

- Self-Pay patients will be identified when they initially contact the office for an appointment. A Self-Pay Patient is defined as a patient who (i) has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, AFLAC, or homeowner's policy; (ii) does not claim third party liability for the patient's health care treatment; (iii) is not eligible for worker's compensation coverage; and (iv) has no other responsible party covering the expenses associated with the care received from St. Charles Orthopaedic Surgery Associates

- If a patient claims to have public or private health insurance coverage but is not able to produce verifiable insurance identification, or if the patient has a "high deductible" insurance plan, or if **the insurance information provided is for a commercial insurance plan in which SCOSA does not participate,** he or she will not be designated as an eligible Self-Pay patient. And in such circumstances, the patient will not be eligible for the Self-Pay discount since the patient has or claims to have some health care coverage.

- Self-pay patients will be required to pay for their services in full, up front, at the time of service for all charges of $250 or less. Charges above $250 can be paid with a Payment Plan arranged with SCOSA's Business Office, but such Self-Pay patients are required to make regular payments and will forfeit the Self-Pay discount if they fail to make all required payments due under the Payment Plan.

- Self-Pay patients eligible for the discount shall be required to sign the attached Application for Self-Pay Patient Discount, certifying to the fact that they have no other coverage and will receive no other funds to pay for any part of the services received in order to be eligible to receive the Self-Pay Discount.

- If Self-Pay patients are on a Payment Plan and fail to make a payment for more than two (2) consecutive scheduled payments then the Self-Pay Discount will be forfeited and the patient will be obligated and required to pay the full charges.

APPLICATION FOR SELF-PAY PATIENT DISCOUNT

1. This Application is made by ___________________________ [insert patient or legal guardian name] in order to obtain the self-pay patient discount offered by St. Charles Orthopaedic Surgery Associates.

2. In order to make its services accessible to patients lacking health care coverage, St. Charles Orthopaedic Surgery Associates offers a significant discount for self pay patients, as explained in the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy. The undersigned hereby states that ________________________ [insert patient or legal guardian name] has reviewed the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy and/or has received information regarding the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy.

3. The undersigned hereby states that _________________________ [insert patient name] is uninsured and meets the St. Charles Orthopaedic Surgery Associates Self-Pay Patient Policy definition of a "Self Pay Patient" because the patient: (i) has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage such as insurance provided by a school, AFLAC, or homeowner's policy; (ii) does not claim third party liability (i.e. auto accident) for the patient's health care treatment; (iii) is not eligible for worker's compensation coverage; and (iv) has no other responsible party covering the expenses associated with the care received from St. Charles Orthopaedic Surgery Associates. **EXCEPTION: Medicaid patients who are seen as a follow-up to an Emergency Room visit, will be eligible for the Self Pay discount if all other requirements are met as outlined in items ii, iii and iv.**

Executed upon my oath at to its accuracy and under penalty of perjury on this _______ day of __________, 20______.

____
Patient or Legal Guardian

____
If Legal Guardian, state relationship to the patient or legal authority

____
Witness

☐ Patient declines self-pay discount for the following reason(s): ____________________________

____

____

Office Use Only

Account #: ____________________ **DOS:** _____/______/_____

Date Posted: ____ /______/_____ **Initials:** __________