SCOS
Orthopedic Specialists

Thank you for choosing **SCOS** Orthopedics.

The physicians and staff of **S**outh **C**ounty **O**rthopedic **S**pecialists want to welcome you to our practice - where we strive to maintain patient satisfaction and to continually ensure the delivery of quality medical services to our patients.

In order for us to provide the quality care you deserve, there are a few things needed for your appointment. Bring your medical insurance card, picture ID and if you have a co-pay, it will be due at the time of visit.

If you have had any testing such as MRI, CT Scan, X-rays, EMG, Bone Scan, etc.... done in relation to your complaint or injury, please bring them with you. It is important for us to have your report of the testing and to be able to view your x-rays. If we are unable to view your x-rays at the time of your visit, we may need to repeat these x-rays or your appointment may need to be rescheduled.

We understand that time is valuable. In order for you to coordinate your time please plan to be in our facility for approximately 60 to 90 minutes. During your visit, we take a comprehensive medical and surgical history, ask you questions about your symptoms and any previous treatments and new x-rays may be taken if indicated by the provider.

Oftentimes, there are question that may arise after your appointment or you may need further clarification about your visit. For non-urgent issues, the patient portal is the best way to contact us. The portal is essentially a secure email system that allows you to ask those questions, request appointments, prescriptions, access your medical and billing records and pay on line. We strongly encourage you to utilize the patient portal.

If for any reason you cannot make your appointment, please call or send a message through the secure email 24 hours prior to your appointment so that we may offer the appointment slot to others.

You can learn more about our physicians and multiple locations by visiting our website at www.scosortho.com. Thank you for choosing SCOS for all your orthopedic needs.

Sincerely,

The Physicians & Staff
SCOS Orthopedic Specialists

SCOS
Orthopedic Specialists

SCOS Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Missed Appointments - Our policy is to charge for missed appointments not canceled within 24 hours of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our charges are as follows:

Office Visit	$50.00
MRI	$75.00
Physical/Hand Therapy	$50.00
Surgery	$250.00

Form Completion – There may be an initial charge of $25.00 to $50.00 for each form a patient may request us to complete such as: DMV forms, Assisted Living forms, health assessments, letter(s) to third parties, etc. A $10.00 fee may apply for disability extensions. If forms or reports are lengthy, charges may be higher depending on the amount of time spent on completion. **This charge is not covered by your insurance.** Please allow 72 hours for completion of forms.

Patient Portal – The patient portal is SCOS's preferred way of communication to our patients. We utilize the portal for exchanging secure messages, medication renewals, appointments referrals and test results.

Co-payments and Deductibles - All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Return Check Charge – All accounts with checks returned from the bank for any reason will be assessed $25.00 per returned check.

Insurance - We participate in most insurance plans, including Medicare and Monarch, Greater Newport and Memorial Care. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Verification of insurance or authorization is not a guarantee of payment. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Non-Covered Services - Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance - All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission - We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. After the initial billing, the patient must assume responsibility in collecting from the insurance company.

Coverage Changes- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment - Patient responsibility is due 15 days upon receipt of billing statement. In the event of late or nonpayment of any portion of patient responsibility you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be responsible for all outstanding balances, including any collection agency fees accrued. As a result, you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Prescriptions - All prescription refills should be requested prior to 4:30pm, Monday – Friday. We do not approve refills prescription during off hours.

Medical Records - Copies of your medical records are available upon request for a $25.00 fee. Please allow 5 working days from receipt of your payment for the records.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

I have read and understand the policy and agree to abide by its guidelines:

Patient Name: (Please Print): _____

Signature: _____

Date: _____

MEDICARE SIGNATURE ON FILE

I request that payment of the authorized Medicare benefits be made on my behalf to **South County Orthopedic Specialists** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item) of the HCFA-1500 form, or elsewhere on other charges approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____	_____	_____
Patient's Name (Please Print)	Patient's Signature	Date

MEDIGAP ASSIGNMENT OF BENEFITS

I request that payment authorized Medigap benefits' be made either to me or on my behalf to South County Orthopedic Specialists for any services furnished by the listed provider/supplier. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

_____	_____	_____
Patient's Name (Please Print)	Patient's Signature	Date

PATIENT'S INSURANCE AUTHORIZATION

I hereby authorize the processing of the medical insurance either by electronic or manual method by the listed facility. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to pay the listed provider assignee. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Payment in full is required at the time of service, for your convenience, we accept personal checks, Visa/MasterCard, as well as cash. Any insurance coverage which you may have is intended to protect you against financial loss, not as payment in full for your care. Payment in full for your care is your responsibility and may not be postponed until the time your insurance reimburses you. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Treatment Authorization: I authorize the treatment by **South County Orthopedic Specialist**. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or liability of another party. I will make sure that my claims are paid promptly.

_____	_____	_____
Patient's Name (Please Print)	Patient's Signature	Date

TREATMENT OF A MINOR

I authorize **South County Orthopedic Specialists** to treat a minor.

_____ (minor)

_____	_____
Signature of Parent/Guardian	Date

RELEASE OF INFORMATION
TO BE COMPLETED BY PATIENT

Please print the telephone number where you want to receive call about your appointments, labs, and x-ray results or other health care information. This may include surgery scheduling information, and post-operative instructions:

Home: _____ Cell: _____
(I am fully aware that a cell phone is not a secure and private line)

May confidential message (i.e. appointment reminders) be left on your answering machine or voicemail? Yes_____ or No_____

_____ _____
Signature of Patient or Legal Guardian **Date**

Please list the family members, significant others, or other persons, if any, whom we may inform about your general medical condition and your diagnosis. This may also include treatment plan, prognosis, payment information and health care options:

Name_____ Relationship_____ Phone_____

Please list family members, significant others, or other persons, if any, whom we may inform about your medical condition *ONLY IN AN EMERGENCY*:

Name_____ Relationship_____ Phone_____

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.

If unable to keep appointment, kindly give 24 hour notice during office hours. A charge may be applied for any un-cancelled appointments.
In the case of a third party liability injury, we do not correspond with any attorney, nor do we appear in court on your behalf. You may request to have your medical records copied by a copy service, which we will be happy to arrange for you. You will be responsible for the copy service fees. There is an additional charge to have x-rays copied. If your insurance requires that insurance forms be completed by us or your medical records copied and sent to them, there is a nominal charge for this service, which will be added to your account.

_____ _____ _____
Patient's Name (Please Print) Patient's Signature Date

South County Orthopedic Specialists
949-586-3200

SCOS
Orthopedic Specialists

Consent to Obtain Electronic Prescription Benefits,

Medication History Information and E-Prescribe

South County Orthopedic Specialists (SCOS) currently participates in the Surescripts system which is a Pharmacy Benefit Manager. This allows for the electronic prescribing of medications, which provides a convenience to patients and physicians and also reduces medication errors. An additional portion of this service allows for the electronic receiving of prescription benefits and medication history such as past prescriptions and dosages filled from other pharmacies. This too, reduces error in medication entry into the electronic medical record and provides your physician with an up-to-date medication profile. By signing below, you give SCOS permission to E-Prescribe and access your information to receive this electronically which will become a part of your electronic medical record.

Print Patient Name: _____

Sign and Date: _____

_____ **I DO NOT** to consent to Electronic Prescription Benefits, Medication History Information and E-Prescribe

Print Patient Name: _____

Sign and Date: _____

Name, address and phone number of your primary pharmacy:

_____

_____

_____

24331 El Toro Road, Suite 200 * Phone 949-586-3200 * Fax 949-900-2158

SCOS
Orthopedic Specialists

Notice of Privacy Practices Acknowledgment

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of your Notice of Privacy Practice. This notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice:

- Our Pledge
- Your personal information
- Our Privacy Practices
- Your written permission
- Other restrictions
- Your rights
- Changes
- Questions or Complaints

We may use your information for:

- Treatment
- Health Information Exchange
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstance & the law

Please understand that this summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number above to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining this signed acknowledgment. If, after reviewing the notice, you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices and the office policies & procedures and do with to receive treatment:

Signature	Printed Name	Date

20. **Workers' Compensation** - We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

21. **Change of Ownership** - In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

22. **Breach Notification** - In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

23. **Research** - We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

C. Your Health Information Rights

Although your health record is the physical property of All about Kids Pediatrics, the information belongs to you. You have the right to:

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way, at a specific location, to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputer information.

D. Changes to this Notice of Privacy Practices

We reserve the right to change our practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website at scosortho.com.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 (fax)
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

POS Reorder # 1006506

NOTICE OF PRIVACY PRACTICES

SCOS
South County Orthopedic Specialists

24331 El Toro Road, Suite 200 • Laguna Woods, California 92637
22 Odyssey, Suite 205 • Irvine, California 92618
18785 Brookhurst St., Suite 100 • Fountain Valley, California 92708
949-586-3200 Main • 949-900-2158 Fax
www.scosortho.com

Effective Date: May 1, 2016

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer.

A. How this Medical Practice may Use or Disclose Your Health Information

The Medical Record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to disclose your health information for the following purposes:

1. **Treatment** - We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. **Health Information Exchange** - This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy.
   Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.
   If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

3. **Payment** - We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

4. **Health Care Operations** - We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. "Business Associates" There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. To protect your health information, however, we require the business associate to appropriately safeguard your information.

5. **Appointment Reminders** - We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

6. **Sign in Sheet** - We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

7. **Notification and Communication with family** - We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

8. **Marketing** - Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

9. **Sale of Health Information** - We will not sell your information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

10. **Required by Law** - As required by law, we will use and disclose your health information, but we will limit our use or disclose to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

11. **Public Health** - We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
    We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

12. **Health Oversight Activities** - We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

13. **Judicial and Administrative Proceedings** - We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

14. **Law Enforcement** - We may, and are sometimes required by law, to disclose health information for law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

15. **Coroners** - We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

16. **Organ or Tissue Donation** - We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

17. **Public Safety** - We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

18. **Proof of Immunization** - We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

19. **Specialized Government Functions** - We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.