COASTAL ORTHOPEDICS

UPPER EXTREMITY NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date of visit: ____ /____ /____ **Who are you seeing today:**___________________________

YOUR INFORMATION

Full name: ________________________________

Date of birth: ____ /____ /_______

Height: ___________ **Weight:** ____________

Hand dominance: ☐ Right ☐ Left ☐ Ambidextrous

Preferred language:

Occupation:

Employment status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Disabled ☐ Military

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Life Partner

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Primary care physician:

Cardiologist (if applicable):

Who referred you to us? ☐ Physician: ____________________ ☐ Friend: ______________________ ☐ Other:__________________

YOUR MEDICATIONS

Are you currently, or will you be initiating, the use of Medical Marijuana for any reason? ☐ Yes ☐ No

Are you taking Aspirin or any other blood thinners? ☐ Yes ☐ No

☐ Yes ☐ No **I consent to securely pull my medications from the pharmacy database, and reconcile with the Medical Assistant**

List all the medications you take, both prescription & nonprescription below:

☐ **No medications to list** ☐ **See attached list of medications**

Medication or Brand Name	Dose	Medication or Brand Name	Dose

YOUR ALLERGIES

☐ **No allergies**

Indicate all the allergies you have to medications and/or food & describe reaction below:
Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

____

YOUR PHARMACY INFORMATION

Do you have a preferred pharmacy that you use? ☐ Yes ☐ No

Pharmacy name:

Pharmacy phone #:

City/State/ZIP:

YOUR PAST MEDICAL HISTORY

☐ **No relevant medical history**

☐ Hypertension	☐ Kidney disease	☐ Obesity	☐ AIDS/HIV
☐ Heart Disease: ______________	☐ Diabetes – I or II	☐ Peripheral vascular disease	☐ Ulcers
☐ Osteoarthritis	☐ Osteoporosis	☐ Anxiety	☐ DVT/blood clots
☐ Rheumatoid arthritis	☐ Cancer– type: ____________	☐ Depression	☐ Stroke

Any additional medical history information:

YOUR PAST SURGICAL HISTORY

☐ **No surgical history**

☐ Hip replacement – RT/LT	Date: ____/____/______	☐ Fracture – Type: ___________________	Date: ____/____/_______
☐ Knee replacement – RT/LT	Date: ____/____/______	☐ Pacemaker	Date: ____/____/_______
☐ Shoulder/rotator cuff – RT/LT	Date: ____/____/______	☐ Open heart/by-pass	Date: ____/____/_______
☐ Carpal tunnel – RT/LT	Date: ____/____/______	☐ Spine – type/level: _______________	Date: ____/____/_______
☐ Arthroscopy – Type: _______________	Date: ____/____/______	☐ Other: ____________________________	Date: ____/____/_______

Any additional surgical information:

COASTAL ORTHOPEDICS

UPPER EXTREMITY NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient name:______________________________

PLEASE INDICATE BELOW STUDIES DONE		
Study	**Date**	**Results**
X-RAYS		
MRI/CT		
EMG/nerve conduction studies		
Myelogram		
Bone scan / DEXA Scan		
EEG		

YOUR FAMILY HISTORY

☐ **Family history unknown**

Mother	Father	Sister	Brother
☐ Alive & well	☐ Alive & well	☐ Alive & well	☐ Alive & well
☐ Cancer– type: ____________	☐ Cancer– type: ____________	☐ Cancer– type: ____________	☐ Cancer– type: ____________
☐ CVA/stroke	☐ CVA/stroke	☐ CVA/stroke	☐ CVA/stroke
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Other: __________________	☐ Other: __________________	☐ Other: __________________	☐ Other: __________________

YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Former ☐ Never **If Current**, have you ever tried to quit? ☐ Yes ☐ No

Type: ______________________________ Packs/Day: __________________________ Years used: __________________________

Alcohol Use: ☐ Yes ☐ No ☐ Former **If Yes**, select type: ☐ Beer ☐ Wine ☐ Liquor

Frequency: ________________________ Amount per sitting: ___________________ Last drink: ___________________________

Which of the following drugs or substances. if any, have you used in the PAST? (Please check all that apply)

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____________

Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____________

REVIEW OF SYSTEMS

☐ **All negative below** **Check if you have any of the following:**

General	Cardiovascular	Metabolic	Skin
☐ Fever	☐ Heart murmur	☐ Cold intolerance	☐ Rash
☐ Weakness	☐ Leg swelling/edema	☐ Heat intolerance	☐ Skin infections
☐ Weight gain/loss (circle one)	☐ Syncope/fainting		☐ Skin lesions
Ears, Nose & Vision	**Gastrointestinal (GI)**	**Neurological**	**Blood Disorders**
☐ Blurred vision	☐ Constipation	☐ Difficulty walking	☐ Bleeding
☐ Facial pain	☐ Diarrhea	☐ Dizziness	☐ Bruising
☐ Headache	☐ Nausea	☐ Poor coordination	
☐ Vertigo/dizziness	☐ Vomiting	☐ Muscle weakness	
Respiratory	**Urinary**	**Psychiatric**	**Immune System**
☐ Dyspnea (difficulty breathing)	☐ Dysuria (difficulty urinating)	☐ Anxiety	☐ Asthma
☐ Recent infections	☐ Frequent urination	☐ Depression	☐ Environmental allergies
☐ Wheezing	☐ Hematuria (blood in urine)	☐ Insomnia	☐ Food allergies

Have you been in the Emergency Room for treatment of your pain? ☐ Yes ☐ No
If yes, when and how often?

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient Signature: **Date:** ____ /____ /____

If Minor, Guardian Signature: **Date:** ____ /____ /____

COASTAL ORTHOPEDICS

UPPER EXTREMITY CONDITION

Patient name: ______________________ Date of birth ___/___/_____ Today's date___/___/_____

Tell us about the reason for your visit today

What is the reason for your visit today?

When did this condition start (onset)?

Place of injury? ☐ Sports ☐ Home ☐ Auto Accident ☐ Workplace ☐ School ☐ Non-applicable

How often does the condition occur? ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent

What is the status of your condition since the onset date? ☐ Unchanged ☐ Improving ☐ Fluctuating ☐ Stable ☐ Worse ☐ Resolved

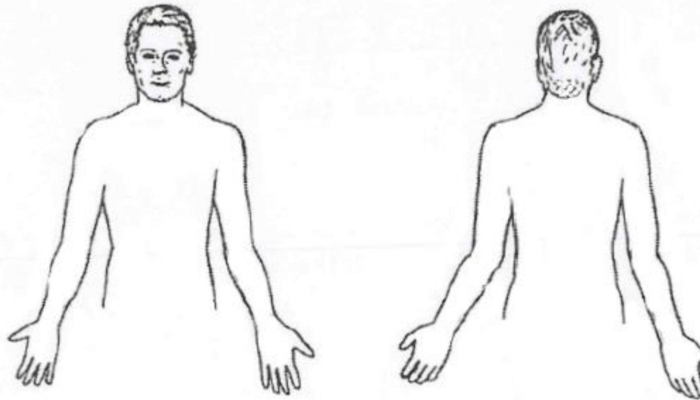
What is the severity of your pain/numbness at its worst? (Circle a number) No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

What type of pain are you experiencing? Check all that apply.

☐ None ☐ Ache ☐ Burning ☐ Discomfort ☐ Dull ☐ Numbness ☐ Piercing ☐ Sharp

☐ Shooting ☐ Stabbing ☐ Electric ☐ Deep ☐ Throbbing ☐ Tearing ☐ Localized ☐ Diffuse

Location of Pain: *On the diagram below **"SHADE"** all areas where you feel pain and **"X" the areas that hurt the most***



Is your condition aggravated by? Check all that apply

☐ Nothing ☐ Daily activity ☐ Movement ☐ Pushing ☐ Pulling ☐ Lifting weight ☐ Carrying items

☐ Showering ☐ Getting dressed ☐ Rotation/ twisting ☐ Sleeping/ lying down ☐ Bending ☐ Grasping an object ☐ Occupational therapy

☐ Weather changes ☐ Exercise ☐Other: ___________________________

Is your condition relieved by? Check all that apply

☐ Nothing ☐ Ice ☐ Heat ☐ Elevation ☐ Mobility ☐ Rest ☐ Stretching

☐ Exercise ☐ Brace ☐ Massage ☐ Physical therapy ☐ Injection ☐ Over the counter meds ☐ Pain medication

Tell us about any past medical treatment

☐Never been treated for condition	Start Date	☑ Receiving now	End Date	Name of facility where treatment was completed	% of relief 0-100
Activity modification	___/___/_____	☐	___/___/_____		
Bracing	___/___/_____	☐	___/___/_____		
Injection/nerve block	___/___/_____	☐	___/___/_____		
Drug/medication therapy	___/___/_____	☐	___/___/_____		
Physical therapy	___/___/_____	☐	___/___/_____		
Physician prescribed home exercise	___/___/_____	☐	___/___/_____		
Resting the area	___/___/_____	☐	___/___/_____		
TENS unit	___/___/_____	☐	___/___/_____		
Other: ___________________	___/___/_____	☐	___/___/_____		

COASTAL ORTHOPEDICS

Musculoskeletal Ambulatory Surgery Center

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

☐ Coastal Orthopedics ☐ MSASC

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge that I have received the attached Privacy Notice.

______________________	______________________	______________________
Patient's Name (Printed)	Patient's Date of Birth	Today's Date

______________________	______________________
Patient Signature	*Guarantor or Personal Representative Signature

*If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: ____

Please answer the following questions to help us protect your privacy:

1) May we leave a detailed message on your answering machine? YES / NO
   - If the answer is YES, please provide phone number:______________________
2) May we leave a message at your place of employment? YES / NO
   - If the answer is YES, please provide phone number:______________________

If the answers to the above questions are NO, please let us know how you wish to be notified by our office:

____

3) May we release information to anyone other than you? YES / NO (i.e. spouse, child, friend, etc.)
If the answer is YES, please list each person:

Name:_______________ Relationship:_______________ Contact Info:_______________

Name:_______________ Relationship:_______________ Contact Info:_______________

Name:_______________ Relationship:_______________ Contact Info:_______________

Please list any doctors you currently see that the physician may need to speak with or obtain records from:

(WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE)

Patient Name (printed)	Social Security Number (last 4 digits only)	Company

The undersigned consents to any treatment or procedures rendered the patient by Coastal Orthopedics under the general and specific instructions of the physician. It is further understood that Coastal Orthopedics is authorized to carry out all instructions of the patient's doctor and that Coastal Orthopedics is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Coastal Orthopedics to provide me with the treatment, and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

The undersigned certifies that (s)he has read the forgoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept it's terms.

- **MEDICARE LIFETIME SIGNATURE AUTHORIZATION and CERTIFICATION FOR PAYMENT**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the group medical practice, furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also request that this authorization apply to all other insurance.

- **MEDIGAP INSURANCE AUTHORIZATION**

I request that payment of authorized Medigap benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to [see copy of Medigap card] any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

- **OTHER INSURANCE AUTHORIZATION**

I request that payment of authorized benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to (see copy of card) any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guarantor	Date
Signature of Witness	Printed Name of Witness

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Coastal Orthopedics to administer treatment as they so deem necessary to my son/daughter.

Signature of Patient or Guarantor	Date
Printed Name of Parent or Guardian	
Signature of Witness	Printed Name of Witness

COASTAL ORTHOPEDICS

Musculoskeletal Ambulatory Surgery Center

PRIVACY NOTICE

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

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

I. Uses and Disclosures of Protecting Health Information for You

All parties listed above may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

If you are being treated for a work-related injury, please note that the privacy practices outlined in this notice are superseded by Florida state law.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription, to a laboratory to order or receive a blood test or to a cardiologist to receive an EKG. We may also disclose protected health information to physicians who may be treating you or consulting with this facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of providing quality care to all patients. Health care operations include such activities as: quality assessment/ improvement activities; employee review activities; training programs including those in which students, trainees or practitioners in health care learn under supervision; accreditation, certification, licensing or credentialing activities; review and auditing, including: compliance reviews, medical reviews, legal services, legal services and maintaining compliance programs, and business management/ general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and health care operation, we may also use or disclose your protected health information for other purposes, such as to remind you of your appointment or to see how you are doing after surgery.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state or local law.

B. When There Are Risks to Public Health . We may disclose your protected health information for the following public activities and purposes:

- To prevent or control disease, injury, or disability
- To report abuse or neglect
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required

C. To Report Suspected Abuse. Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including: audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- Under certain limited circumstances when you are the victim of a crime
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct
- In an emergency to report a crime

G. To Coroners, Funeral Directors and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner/medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security/intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions and law enforcement custodial situations.

K. For Worker's Compensation. The facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care. We may also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

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

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization, in writing, at any time except to the extent that we have taken action in reliance upon any authorization taken prior to your revocation or change.

V. Your Rights

You have the following rights regarding your health information:

A. The Right to Inspect and Copy Your Protected Health Information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the facility uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action/proceeding or protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

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

To inspect and copy your medical information, you must submit a written request to our Medical Records Department. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The Right to Request to Receive Confidential Communications From Us by Alternative Means or at an Alternative Location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests other than those accommodated by our general release form must be made in writing to our Privacy Officer.

D. The Right to Request Amendments to Your Protected Health Information. You may request an amendment of protected health information about you, including billing information, for as long as we maintain this information. We may require that such requests be put in writing, that a valid and legal reason be supplied and that such requests be directed to the Privacy Officer. In certain

cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and we will provide you with a copy of any such rebuttal. Requests for amendments shall be handled in accordance with the timeliness guidelines outlined in the Privacy Act. All revisions or changes to a medical record must be done in consultation with the physician and in accordance with applicable state law on medical record amendments.

E. The Right to Receive an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for: disclosures that you requested; disclosures that you agreed to by signing an authorization form; to friends or family members involved in your care or certain other disclosures we are permitted to make without your authorization. The request for an accounting of disclosures must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting of disclosures. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting of disclosures requests may not be made for periods of time in excess of six years. We will provide the first accounting for disclosures you request during any 12-month period without charge. Subsequent accounting for disclosures requests may be subject to a reasonable cost-based fee.

F. The Right to Obtain a Paper Copy of this Notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The CPW is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain.

VII.Complaints

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally, in writing or via e-mail using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Coastal Orthopedics
6015 Pointe West Boulevard
Bradenton, Florida 34209
ATTN: Privacy Officer

The Privacy Officer can be contacted by telephone at 941-792-1404 or via e-mail at privacyofficer@coastalorthopedics.com

IX. Effective Date

This Notice is effective April 14, 2003