

Jack L. Siegel, MD, FAAOS
James E. Dowd, MD, FAAOS
Nicholas A. Midis, MD, FAAOS
Kevin F. Bonner, MD, FAAOS
Louis C. Jordan, MD, FAAOS
Samuel P. Robinson, MD, FAAOS
Joseph S. Gondusky, MD, FAAOS
Justin W. Griffin, MD
Jeffrey J. Laurent, MD, FAANS
David A. Vincent, MD, FACS
Parker W. Babington, MD
Scott I. Horn, DO
David S. Levi, MD



Travis Farrell, PA-C
Sabrenia Gill, PA-C
Kara P. Hood, PA-C
Derek W. Joyner, OA-C
Linda H. Liebold, PA-C
Rebekah Macaskill, PA-C
Tamaryn Parks, PA-C
Angela Rivera NP-C
Michelle Smith, NP-C
Sara Tyszko, PA-C
Sean Wren, PA-C

Louis R. Jordan, MD, *Emeritus*
David B. Young, MD, *Emeritus*

Jim McNamara, CEO

Welcome to the Jordan-Young Institute for Orthopedic Surgery, Sports Medicine, Neurosurgery, and Physical Medicine & Rehabilitation. Thank you for choosing us to serve you. It is our pleasure to assist you in improving your quality of life with medical and surgical options that will maximize your mobility and minimize your pain.

In this packet, you will find both information about our practice and forms you must complete for us to assist in your care. Please read these forms carefully and fully complete each one prior to your appointment. In addition to these completed forms, you will need to bring the following to your appointment:

- Your current insurance cards
- Photo identification
- A referral from your primary care provider, if required by your insurance carrier
- Films and reports from any pertinent diagnostic testing, such as x-rays, MRIs, EMGs, CT scans, and bone density studies
- Any co-payment and deductible payments that your insurance coverage holds you responsible for to receive care. We accept cash, check, VISA, MasterCard, Discover, and American Express. Your appointment will be rescheduled if you cannot pay your co-pay before being seen.

PLEASE PLAN TO ARRIVE 30 MINUTES PRIOR TO OUR SCHEDULED APPOINTMENT TIME so that we can complete your registration, medical record and x-rays prior to your appointment with the physician. Even if you bring x-rays or other diagnostic tests with you, your physician may require additional films to be taken in our office. Dress in comfortable clothing that will allow your physician to easily view the injured or painful areas of your body. While your physician strives to maintain a timely office schedule, please realize that some wait time may occur. Our physicians give each patient the time necessary to understand their condition and the options available for treatment.

If you have additional questions about our practice, our providers, or your appointment, please visit our website at www.Jordan-YoungInstitute.com or call our office at (757)490-4802.

Again, thank you for choosing Jordan-Young Institute. We look forward to seeing you.

DIRECTIONS TO JORDAN-YOUNG INSTITUTE

5716 Cleveland Street, Virginia Beach, VA – (757)490-4802 - www.Jordan-YoungInstitute.com

Jordan-Young Institute is located on **Cleveland Street off Newtown Road**. Cleveland Street from the Pembroke area ends at Clearfield. There is no direct roadway to Jordan Young Institute on Cleveland Street coming from the east.

FROM NORFOLK/PORTSMOUTH

- Take 264 East
- Exit toward 1-64 E/Chesapeake/Newtown Road
- Take Newtown Road (Exit 15A - stay to the left when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on the left (the name is on building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

FROM THE BEACH

- Take 264 West
- Exit Newtown Road (Exit 15)
- Turn right onto Newtown Road.
- Turn right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

FROM CHESAPEAKE

- Take Route 64 to Route 264 exit toward Virginia Beach.
- Take Newtown Road (Exit 15A- stay to the left when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

FROM HAMPTON AND NEWPORT NEWS AREA

- Take 64 East
- Exit Newtown Road. (Exit 284B)
- Take Newtown Road (Exit 15A- stay to the left when exiting)
- Left on Newtown Road. Go down three traffic lights.
- Right onto Cleveland Street (Patient First is on the corner)
- Jordan-Young Institute is first business building on left (the name is on the building)
- Our office is on the second floor
- **Please note Dr. Horn & Dr. Levi's office is on the 1st floor - Suite 140**

PLEASE BRING YOUR INSURANCE CARDS AND THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT



PATIENT INFORMATION

ACCOUNT # _____

PATIENT NAME _____ MAIDEN/OTHER NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

AGE _____ DATE OF BIRTH _____ MALE FEMALE MARITAL STATUS _____

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ EMPLOYER PHONE _____

OCCUPATION _____

PRIMARY CARE PROVIDER _____

REFERRING PHYSICIAN _____

RESPONSIBLE PARTY OR SPOUSE

NAME _____ MAIDEN/OTHER NAME _____

ADDRESS _____

CITY _____ STATE _____ DATE OF BIRTH _____

HOME PHONE _____ SOCIAL SECURITY # _____

CELL PHONE _____ OCCUPATION _____

EMPLOYER _____ EMPLOYER PHONE _____

PRIMARY HEALTH INSURANCE INFORMATION

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY NUMBER _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: SELF SPOUSE CHILD OTHER

GROUP # _____

SECONDARY HEALTH INSURANCE INFORMATION

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY NUMBER _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: SELF SPOUSE CHILD OTHER

GROUP # _____

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT _____

TELEPHONE _____ RELATIONSHIP _____

I HEREBY CONSENT TO TREATMENT by Jordan Young Institute physicians, their associates, and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances and/or other procedures as deemed necessary.

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Jordan-Young Institute, P.C. healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

DISABILITY / FMLA FORM INFORMATION

Jordan-Young Institute, P.C. staff will complete all disability and/or FMLA forms that you require, within two weeks of the date requested. We are unable to complete forms while you wait. We require a fee of \$35 for completion of all disability and FMLA forms.

PATIENT AUTHORIZATION

I authorize Jordan-Young Institute, P.C. to release medical information necessary to submit my health insurance or Worker's Compensation Claims. I request that my health insurance or Worker's Compensation claims be paid directly to Jordan-Young Institute, P.C. In consideration of the services rendered, I/we agree and understand that each person(s) signing this document jointly and severable agrees to pay for all services rendered by Jordan-Young Institute, P.C. If this account is referred to an outside collection agency or attorney, then the undersigned person(s) agree and promise to pay all collection costs including attorney fees of 33 1/3 % of the principal amount due and owing when turned over for collection and do further agree to pay interest on the unpaid balance at the legal rate from the date services were last rendered. I authorize photocopies of this form to be valid as the original.

POLICY FOR FORMS COMPLETION AND THE COPYING OF MEDICAL RECORDS AND X-RAYS

Any request for medical records require a medical release to be completed. Medical records will be filled within two weeks of date requested. Please see medical release form for all charges that may apply. Please allow one week for any request of x-ray films. There will be a charge of \$5 per x-ray film.

PRESCRIPTION REFILL POLICY

To request a prescription refill, please call us Monday through Friday, from 9:00a.m. to 4:00 p.m. Please allow 24 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be ordered after hours or on weekends. Please remember to call us in advance so that we can assist you in a timely manner.

CLINICAL RESEARCH ACTIVITY

The physicians of Jordan-Young Institute are involved in clinical research studies and trials and work closely with Jordan Research Foundation. The companies sponsoring these studies and trials provide financial support for research staff as well as for activities the physicians perform outside of clinical practice. These activities may include consulting, advisory boards, giving speeches and/or presentations, or writing reports. If you would like more information please ask to speak with the Jordan Research Foundation's Research Coordinator.

Patient Signature: _____ **Date:** _____

Patient or Guardian's Signature: _____ **Date:** _____

Relationship to Patient _____

PATIENT HISTORY

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT



PATIENT NAME _____ TODAY'S DATE _____
LAST FIRST MIDDLE

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

PRIMARY CARE PHYSICIAN'S NAME/ADDRESS _____

REFERRING PHYSICIAN'S NAME/ADDRESS _____

YOUR PRIMARY PROBLEM/COMPLAINT _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT IS THE SEVERITY OF YOUR PAIN (CIRCLE ONE) NONE 1 2 3 4 5 6 7 8 9 10 Unbearable

IS YOUR PAIN: IMPROVING WORSENING STAYING THE SAME

WHAT IMPROVES YOUR SYMPTOMS OR MAKES THEM WORSE? _____

IS THIS A PROBLEM DUE TO AN ACCIDENT? YES NO

IS THIS A WORKERS COMP CLAIM? YES NO

HOW DID THE INJURY OCCUR (SPORTS, WORK, MOTOR VEHICLE ACCIDENT)? _____

WHERE DID THE INJURY OCCUR? _____ DATE OF INJURY _____

HAVE YOU HAD X-RAYS, MRIs, or CTs PERFORMED ELSEWHERE RELATED TO THIS PROBLEM? YES NO
IF YES, PLEASE EXPLAIN _____

HAVE YOU BEEN EXAMINED BY A PHYSICIAN FOR THIS COMPLAINT BEFORE? YES NO
IF YES, LIST PHYSICIAN _____

HAVE YOU BEEN TOLD THAT YOU NEED SURGERY, OR EVER HAD SURGERY RELATED TO THIS? YES NO
IF YES, LIST PHYSICIAN _____

DO YOU SMOKE? YES NO IF YES, HOW OFTEN/HOW LONG: _____

DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MUCH/OFTEN: _____

HAVE YOU EVER HAD A DRUG ADDICTION? YES NO IF YES, HOW LONG AGO: _____

CONTINUE TO BACK →



MEDICAL AND SURGICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH:	YES	NO	LIST ANY OTHER MEDICAL CONDITIONS OR TREATMENTS BELOW:
DIABETES TYPE 1 OR TYPE 2			
HYPERTENSION			
ASTHMA			
KIDNEY DISEASE			
ULCERS			
GASTRITIS			
HEPATITIS			
HIV			
SEIZURES			
BLEEDING DISORDERS			
CANCER			

PLEASE LIST ANY PREVIOUS SURGERIES AND THE APPROXIMATE YEAR

SURGERY	YEAR	SURGERY	YEAR

PLEASE LIST ALL MEDICATION ALLERGIES

MEDICATION	REACTION

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) THAT YOU ARE CURRENTLY TAKING

MEDICATION	DOSE	FREQUENCY

FAMILY HISTORY

PLEASE INDICATE THE HEALTH STATUS OF YOUR FAMILY MEMBERS

- MOTHER _____ ALIVE DECEASED
- FATHER _____ ALIVE DECEASED
- BROTHER _____ ALIVE DECEASED
- SISTER _____ ALIVE DECEASED
- CHILD _____ ALIVE DECEASED
- CHILD _____ ALIVE DECEASED
- RELATIVE _____ ALIVE DECEASED
- RELATIVE _____ ALIVE DECEASED



REVIEW OF SYSTEMS

CONSTITUTIONAL				GENITOURINARY			
Excessive Fatigue	Yes	No		Difficult Urination	Yes	No	
Exercise Intolerance	Yes	No		Kidney stones	Yes	No	
Chills	Yes	No		Frequency	Yes	No	
Fever	Yes	No		Urgency	Yes	No	
Unexpected weight loss	Yes	No		Flank pain	Yes	No	
Unexpected weight gain	Yes	No		Bleeding	Yes	No	
EYES				Painful urination	Yes	No	
Glaucoma	Yes	No		Bladder infection	Yes	No	
Cataracts	Yes	No		SKIN			
Blurred/double vision	Yes	No		Lesion color change	Yes	No	
Redness	Yes	No		Rash	Yes	No	
Pain	Yes	No		Itching	Yes	No	
ENT				Redness	Yes	No	
Infected or painful teeth	Yes	No		Skin changes	Yes	No	
Headache	Yes	No		Poor healing	Yes	No	
Difficulty swallowing	Yes	No		NEUROLOGICAL			
Nose bleeds	Yes	No		Head injury	Yes	No	
Ringling/Pain in ears	Yes	No		Seizures	Yes	No	
CARDIOVASCULAR				Numbness/tingling	Yes	No	
Chest pain	Yes	No		Stroke	Yes	No	
Heart murmurs	Yes	No		Dizziness	Yes	No	
High blood pressure	Yes	No		Tremors	Yes	No	
Palpitations	Yes	No		HEMATOLOGIC			
Irregular pulse	Yes	No		Easy bleeding/bruising	Yes	No	
Fainting	Yes	No		Blood clots	Yes	No	
Vascular disease	Yes	No		Blood transfusion	Yes	No	
RESPIRATORY				ENDOCRINE			
Asthma	Yes	No		Heat/cold intolerance	Yes	No	
Snoring	Yes	No		Excessive thirst/urination	Yes	No	
Cough	Yes	No		ALLERGIC			
Pulmonary edema	Yes	No		Reaction to foods	Yes	No	
Shortness of breath	Yes	No		Reaction to environment	Yes	No	
Wheezing	Yes	No		PSYCHIATRIC			
Pain with a deep breath	Yes	No		Nervousness	Yes	No	
GASTROINTESTINAL				Anxiety	Yes	No	
Heartburn	Yes	No		Depression	Yes	No	
Nausea	Yes	No		Hallucinations	Yes	No	
Vomiting	Yes	No					
Constipation	Yes	No					
Diarrhea	Yes	No					
Bloody/Tarry Stools	Yes	No					

Patient Signature _____ Date _____

Reviewed with patient

Physician Signature _____ Date _____

IF YOUR VISIT IS FOR YOUR HIP OR KNEE, PLEASE COMPLETE THIS FORM



REASON FOR YOUR VISIT – (CIRCLE) HIP KNEE - LEFT RIGHT BOTH _____

WHERE IS THE PAIN? (CIRCLE) FRONT BACK INNER OUTER ALL OVER _____

HAVE YOU TRIED ANY OF THE FOLLOWING? SPECIFY LENGTH OF TIME AND TYPE

THERAPY _____ HOME EXERCISE _____ WEIGHT LOSS _____ LBS

ASSISTIVE DEVICE CANE _____ WALKER _____ BRACE _____

ANTI-INFLAMMATORY MEDICATION (PREVIOUS AND CURRENT) INCLUDE DURATION OF USE

ALEVE/NAPROXEN _____ MOTRIN/IBUPROFEN _____ CELEBREX _____

MOBIC/MELOXICAM _____ OTHER _____

HAVE YOU HAD INJECTIONS FOR THIS PROBLEM? SELECT ALL THAT APPLY:

CORTISONE/STEROID DATE OF LAST INJECTION: _____ HOW MANY TOTAL? _____

VISCOSUPPLEMENTATION DATE OF LAST INJECTION: _____ HOW MANY TOTAL? _____

(SYNISC, EUFLEXXA, HYALGAN)

HAVE YOU HAD SURGERY ON THIS BODY PART? (SCOPE OR OTHER? WHEN?) _____

HAVE YOU HAD ANY OTHER TREATMENT NOT LISTED? _____

HAVE YOU SEEN OTHER PROVIDERS FOR THIS CONDITION (WHO/WHEN?) _____

PAIN AT NIGHT Y OR N **DIFFICULTY SLEEPING** Y OR N **BACK PAIN** Y OR N

PAIN: MILD MODERATE SEVERE TOTALLY DISABLING **LIMP:** MILD MODERATE SEVERE UNABLE TO WALK

NEED ASSISTANCE: NONE CANE AT TIMES CANE FULL TIME WALKER WHEELCHAIR

CAN YOU WALK 1/4 OF A MILE (OR 2 CITY BLOCKS) WITHOUT PAIN: Y OR N

CAN YOU CLIMB STAIRS: NORMAL WITH THE RAIL WITH DIFFICULTY UNABLE

CAN YOU PUT ON SOCKS AND SHOES: WITH EASE WITH DIFFICULTY UNABLE

WHAT IS YOUR ACTIVITY LEVEL?

BEDRIDDEN SEDENTARY SEMI-SEDENTARY LIGHT LABOR MODERATE/HEAVY LABOR

WHAT ARE SOME EXAMPLES OF HOW YOUR PAIN IMPACTS YOUR DAILY LIFE (THINGS YOU CAN NO LONGER DO OR DO COMFORTABLY)? _____

FINANCIAL POLICY

Thank you for choosing Jordan-Young Institute. We are committed to providing you with the best patient care experience possible. As part of this goal, we would like to explain our payment policies before your treatment begins so you have the chance to ask questions before any payment obligation occurs. We feel that helping you understand your payment expectations and obligations ahead of time will help us provide you with the quality of compassion and care you expect from our practice.

For your convenience, we have answered a variety of commonly asked questions about payment policies. If you do not find the answer to your specific questions, please ask to meet with appropriate staff who can help.

DO YOU ACCEPT MY INSURANCE AS PAYMENT IN FULL?

We are participating providers with Medicare, Cigna, Sentara Optima, Blue Cross Blue Shield and Healthkeepers, Aetna, Humana, Tricare Standard, United Healthcare, VHN, and PHCS. This means that we will accept the insurers allowable as payment in full. **You, however, are still responsible for payment of any deductibles, co-insurance or co-pays as defined by your insurance coverage. Your office visit will be rescheduled if you are unable to pay your co-pay or provide a referral (if necessary) before you are seen.**

We do not participate with Aetna HMO, Today's Option Medicare Advantage or any of the Medicare-Medicaid dual-eligibility programs, however, we will assist you in determining your benefit coverage. We do not offer payment plans but we can refer you to an external agency should you need to make such arrangements.

We do not participate with Healthkeepers Plus and Sentara Family Care.

WHEN DO I HAVE TO PAY FOR SERVICES?

You are expected to pay all co-pays, co-insurance and unmet deductibles on the day of your visit. We accept VISA, MasterCard, Discover, and American Express as well as payment by cash or check. **If you are unable to pay, your appointment will be rescheduled.**

You are expected to pay for all non-covered services and DME Cash and Carry Items at the time of issue. We will gladly hold an item for you until you are able to pay.

MAY I STILL BE SEEN IF JORDAN-YOUNG DOES NOT PARTICIPATE WITH MY INSURANCE?

If you do not carry insurance we participate with, your policy may have out-of-network benefits. It is your responsibility to call your insurance carrier to determine and understand your benefit coverage. Jordan-Young will file a claim to your insurance as a courtesy to you; however, we are not obligated to accept your insurance's payment as payment in full. **You may be balance billed for the difference between our charge and the amount your insurance pays.**

DO I NEED A REFERRAL TO BE SEEN?

Many insurance plans now provide open referral networks; however, **it is your responsibility to determine and understand if your individual insurance coverage requires a referral.** If your insurance requires a referral, you must have the referral available at the time of your appointment. If you do not have the referral with you, you will be asked to either 1) Reschedule your appointment to give you time to obtain the referral or 2) Sign a waiver that will make you responsible for payment in full of the charges incurred on the day's visit.

Tricare Prime patients must obtain a referral before being scheduled for an appointment.

SIGNATURE ON BACK →

DO I HAVE TO PAY IF I HAVE BEEN INJURED IN AN ACCIDENT?

Jordan-Young does not accept legal cases or attorney liens. If you have been injured in a non-work-related accident for which you are seeking legal remedy, you will be required to pay 100% of your billed charges before being seen. **Your medical insurance cannot be billed.**

If you have been injured in a work-related accident, **it is your responsibility to obtain an award number from the state Workers' Compensation Commission** in order to ensure that your claim will be paid in full. If you are treated without the award number from the state and your payment of your claim is denied or only paid in part by your employer, you will be held responsible for the balance of your bill.

Jordan-Young accepts fee schedule payments for injured workers covered under the United States Department of Labor, Jones Act, Longshoreman's Act and Sentara Health Systems.

MAY I SET UP A PAYMENT PLAN?

Payment is expected in full at the time services are rendered. **If you are not able to pay the patient responsible balance of your bill at the time of service, Jordan-Young retains the right to refer your account to AMC for collection. AMC will attempt to negotiate reasonable payment terms with you and will accept most forms of payment. If you fail to keep the agreed payment terms, further collection activities will ensue. You will be responsible for fees and any other associated costs incurred in collecting on your account.**

Co-insurance and deductible balances after insurance are expected to be paid within 30 days of receiving your first patient statement. If your account balance is still unpaid after 31 days, **your account will be referred to Account Management Company AMC for collections. AMC is not a collection agency, but rather an external bill paying service. However, if you default on your payment arrangements or do not pay your outstanding bill, your outstanding account will be immediately transferred to a collection agency. You will be responsible for the balance due on your account plus any non-negotiable fee assigned by the collection agency in satisfying the payment of your account balance.**

You will be responsible for contacting Credit Control Corporation and AMC at either (757)873-3332 or 1-(800)723-5431 for making time-based payment arrangements or collections payments.

WHAT HAPPENS IF I MISS AN APPOINTMENT OR HAVE A CHECK RETURNED?

Jordan-Young reserves the right to charge a NO SHOW fee of \$50 for any missed appointment. This fee must be paid before another appointment is scheduled.

Jordan-Young reserves the right to charge a RETURN CHECK fee of \$35 for any payment by check that is returned for insufficient funds.

I have read and fully understand the policies of this office regarding payment. I agree to pay any known patient responsible obligations at the time of service or any obligations identified as my responsibility within 30 days of notification by my insurance or Jordan-Young. I understand that collection of my patient responsible balances outside these terms may be handled by an outside collection agency and I will be responsible for both the balance of the bill and any non-negotiable fees assigned for collection. I understand that I am personally responsible for following the regulations, policies and procedures of my insurance plan.

Patient Signature

Date

Printed Name

Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations (HIPAA)

I consent to the use or disclosure of my protected health information by Jordan Young Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jordan Young Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jordan Young Institute has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Jordan Young Institutes' Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Jordan Young Institute. The Notice of Privacy Practices for Jordan Young Institute is also provided in the lobby and on the group website at www.jordan-younginstitute.com. This Notice of Privacy Practices describes my rights and responsibilities and Jordan Young Institutes' duties and actions with respect to my protected health information.

Jordan Young Institute reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have been told about and offered to receive a copy of the Notice of Privacy Practices.

Release of Information: I hereby give Jordan Young Institute permission to release information on my medical condition to the following people:

Name and Relationship

Name and Relationship

Name and Relationship

I understand that the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

Patient Signature

Date

Printed Name

Parent or Personal Representative
refused to sign acknowledgment

____ Staff Initials
____ Date

I would like to **RESTRICT DISCLOSURES** "to the insurance company" for services paid for out of pocket.

Patient Signature _____

Date of Service _____