



Automobile Accident Injury Form

"Any person who knowingly and with intent to defraud any insurance company, or other persons, files a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties."
This statement is required by the New Jersey Fraud Prevention Act of 1983.

Name _____ Home Phone _____ Work Phone _____

Address _____ DOB _____ SS# _____

Date & Time of Accident _____ Place of Accident (Street) _____ City _____ State _____

Brief Description of Accident

Do you or any member of your household own an automobile? ☐ Yes ☐ No

Name of Automobile Insurance Company: _____

Were you the driver of the automobile? ☐ Yes ☐ No

Were you a passenger in the automobile? ☐ Yes ☐ No

Were you a pedestrian? ☐ Yes ☐ No

Were you a member of your automobile owner's household? ☐ Yes ☐ No

As a result of the accident, were you injured? ☐ Yes ☐ No

If yes, complete the remainder of this form.

Signature: _____ Date: _____

Describe your injury:

Were you treated by a Doctor?

☐ Yes ☐ No

Doctor's name and address



If you were treated in a hospital, were you
☐ In-Patient ☐ Out- Patient

Hospital name and address _____

Amount of medical bills to date:
\$ _____

Will you have more medical expense
☐ Yes ☐ No

At time of accident were you working
☐ Yes ☐ No

Did you lose wages or salary as a result of
Your injury? ☐ Yes ☐ No

If yes, amount lost to date:
\$ _____

What is your average weekly wage or salary
\$ _____

If you lost wages: Date disability from work began _____ Date returned to work _____

Have you received or are you eligible for benefit under:

If yes, Amount per week

Per Month

- | | |
|--------------------------------|--|
| 1. Workers Compensation Law? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Employees Temp. Disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Medicare? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

List the name and Address of your Employer and other Employers for one year prior to accident date and give occupation and dates of employment:

Employer Name and address

Occupation

From

To

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature: _____ Date: _____

Do Not Detach

Authorization for Medical Information

This authorization of photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and progress. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Do Not Detach

Authorization for Wage and Salary Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____



No Fault Authorization for Health Information Disclosure Patient Information

Patient Name: _____ Street Address: _____
City: _____ State: _____ Zip Code: _____ Date of Birth: _____
Claim Number: _____ Date of Injury: _____
I hereby authorize: _____
(Insurance Company Name)

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to:

Genesis Orthopaedic and Spine
116 S. Euclid Ave, Suite 1
Westfield, NJ 07090
Ph: (908) 588-2311
Fax: (908) 588-2319

Please indicate the information or type of information to be disclosed:

All Independent Medical Examination Reports for Orthopaedic and Pain Management & Rehabilitation.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released to this authorization. I understand that the information release pursuant to this authorization is subject to redisclosure by the recipient and may no longer be protected by the HIPAA rule. Unless otherwise revoked, this authorization will expire in six months or on the following date:

_____.

I understand that any disclosure of information may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information disclosed. I understand that authorizing this disclosure is voluntary.



I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization. I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION NOTED IN THE PRECEDING PARAGRAPH TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

Signature of Patient or Authorized Representative

Date

Description of Representative's Authority (witness signature required)

Signature of Witness

** A photostatic copy of the within authorization shall be as effective and valid as the original.



New Patient Registration

Date/Fecha _____

Last Name/ Apellido: _____		First Name/ Nombre: _____		MI/ I: _____
Date of Birth/ Fecha de Nacimiento: _____		Age/Edad: _____		
SS Number/Numero de S. Social: _____		Marital Status/Estado Marital: S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/>		
Address/ Dirección: _____				
City/Ciudad: _____		State/Estado: _____		
Zip Code/ Codigo Postal: _____		Phone Number/ Telefono: _____		
Ethnicity: <input type="checkbox"/> Nonhispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Race: _____		
Language Spoken: _____				

Employer's Name, Address/ Compania de Trabajo, Dirección: _____

Occupation/ Ocupación: _____ **Phone #/ Telefono #:** _____

Method of Payment ☐ Insurance ☐ Cash

Primary Insurance Carrier/Seguro Primario: _____

Subscriber ID Number/Numero de Subscriber: _____

Insured's or Responsible Party

Last Name/ Apellido: _____ **First Name/Nombre:** _____

Insured's Email Address/Email del Asegurado: _____

How were you referred to us?/Quien lo refirio a nosotros? _____

Do you have a preferred pharmacy? _____

Do you have a primary care physician? _____

☐ I give GOS my permission to check outside sources regarding my prescription history

☐ I have received GOS's HIPAA Compliance Regulations

Signature/ Firma: _____

Date/ Fecha: _____

Witness Signature: _____ **Date:** _____

Patient Chief Complaint and History Form

Date: _____ Phone Number: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City, State, Zip: _____

Chief Complaint/ History of Present Illness (What is the reason for your visit today, be specific)

Past Medical History

Have you ever had any of the following?

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Migraines | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Surgical Operations | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> STD |

Are you on any medications? Y ☐ N ☐ (If yes, list all): _____

Do you have any allergies? Y ☐ N ☐ (If yes, list all): _____

Please list any hospitalizations or surgeries with dates: _____

Family History

Has any close relative had any of the following listed below?

- | | | | |
|--|---|--|-----------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rare Disorder | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Stroke |

If yes please list which family member: _____

Social History

Do you smoke? Y ☐ N ☐

Do you drink alcohol? Y ☐ N ☐

Do you use any street drugs? Y ☐ N ☐

Review of Symptoms

Do you currently have any of the following problems? Please check Yes or No

Fever/Chills	Y <input type="checkbox"/> N <input type="checkbox"/>	Chest pain	Y <input type="checkbox"/> N <input type="checkbox"/>	Cough	Y <input type="checkbox"/> N <input type="checkbox"/>
Weight loss	Y <input type="checkbox"/> N <input type="checkbox"/>	Palpitations	Y <input type="checkbox"/> N <input type="checkbox"/>	Sleep Apnea	Y <input type="checkbox"/> N <input type="checkbox"/>
Vision Change	Y <input type="checkbox"/> N <input type="checkbox"/>	Diff. Breathing	Y <input type="checkbox"/> N <input type="checkbox"/>	Abdominal Pain	Y <input type="checkbox"/> N <input type="checkbox"/>
Constipation	Y <input type="checkbox"/> N <input type="checkbox"/>	Diarrhea	Y <input type="checkbox"/> N <input type="checkbox"/>	Dizziness	Y <input type="checkbox"/> N <input type="checkbox"/>
Joint Pain	Y <input type="checkbox"/> N <input type="checkbox"/>	Muscle Pain	Y <input type="checkbox"/> N <input type="checkbox"/>	Vomiting	Y <input type="checkbox"/> N <input type="checkbox"/>

Please note that we trust that all information in this form is true to the best of your knowledge. Proper medical treatment starts with the information the patient provides to the doctor. Also note that the doctor will only discuss complaints that have been listed on this form, anything left out will have to wait for another visit.

This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

By signing below, I acknowledge that I fully understand everything listed above:

Patient Signature

Witness Signature

Date



Cancellation Policy/ No Show Policy For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to seemingly "full" appointment book.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 30 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/ No Show Policy for Procedures

Due to the large block of time needed for surgery and other extensive appointments, last minute cancellations can cause problems and added expenses for the office.

If surgery, concussion, PRP, Lipogems, and BMAC is not cancelled at least 24 hours in advance, or if you are a no-show for your appointment, you will be charged a \$150 fee; this will not be covered by your insurance company.

(Signature)

(Date)

(Printed Name)



Emergency Contact Information

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Genesis Orthopaedic and Spine to disclose your PHI to following individuals.

Name: _____

Relationship to Patient: _____

Telephone: (_____) _____ - _____

Email: _____

Name: _____

Relationship to Patient: _____

Telephone: (_____) _____ - _____

Email: _____



You authorize **GOS** scheduled charges to your credit card. You will be charged the amount indicated below for any service obtained (Insurance Deductible, Co-pays, Procedures, etc.), in the event not covered by insurance or after payment arrangement made e.g. checks. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize **GOS** to charge my Credit Card
(Cardholder's Name)

indicated below for \$ _____ on the _____ of each _____.
(Amount) (Day) (Month)

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ / ____

CVV ____

Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **GOS** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____

DATE _____

Financial Policy and Patient Agreement

We understand that choosing a health care provider is an important decision and we appreciate you choosing Genesis – Orthopaedic and Spine (GOS). We are happy to explain our services, our financial policies, and the fees for our services, or the basis for determining the fees to be charged and answer any questions you may have. We will provide a list of our current fees for standard services, upon request.

We do not charge a fee for preparing an insurance claim form on your behalf. We will charge a missed appointment fee if you fail to notify us at least twenty-four (24) hours in advance of your scheduled appointment.

We also know that insurance plans and payments are increasingly complex for our patients. We want you to understand your benefits and the financial arrangements for paying for the cost of your care. We will provide you a list of health insurers with which we are in-network, including Medicare. We do accept out-of-network benefits for all other insurance plans. These out-of-network benefits are different than if you received services from an in- network provider. Your insurance plan may require multiple copays, higher deductibles, and coinsurance. Coverage will depend on the type of plan you have chosen. The amount, or estimated amount, that we will bill you for our services is available to you upon request and will be explained to you prior to providing services.

Financial Responsibility

As used below, “you” and “your” mean the patient/person financially responsible for payment for the patient’s care.

Although you are responsible for the entire bill when the services are rendered, it is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you. While we will make a good faith attempt to verify your benefits prior to the first appointment, this is no guarantee that our services will be completely covered. You are responsible for understanding the details of your health insurance coverage, as well as fulfilling any requirements for coverage, such as pre-authorizations. Required co-payments and estimated co- insurances are to be made as services are rendered.



Arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known.

If any payments of medical benefits are made directly to you for services rendered by GOS, you must remit such payment directly to GOS within ten (10) days of receipt. We will ask you to sign an Assignment of Benefits authorizing us to receive payments from your health plan for the services we rendered to you.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for the total amount of your charges if your Workers' Compensation claim is denied.

As a service to you, we will keep a copy of your insurance card on file and will submit an insurance claim on your behalf to your insurance company with the information you have provided us. You must provide accurate information and any updates to your insurance information. Payment options at the time of service include cash, check or credit card. With your authorization, we will charge an approved credit card for the patient balance as determined by the insurance company once we have submitted a claim and received the Explanation of Benefits.

If your medical benefits are not paid within thirty (30) days, the balance will be due in full from you. If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and reasonable attorney fees, as allowed by law.

Financial hardship should never stand in the way of needed services. A determination of financial hardship can only be made on a case-by-case basis, in compliance with all of the rules applicable to our practice. Upon obtaining necessary information from you, we can make a good faith determination as to whether your circumstances constitute a financial hardship and what payment plan options you may have, including installment payments. Please speak to our patient advocate if you have any questions about our financial hardship policy.

Patient Agreement:

I have been informed if any of the services rendered to me by GOS will be reimbursed at an out-of-network level. I knowingly, voluntarily and specifically select GOS as my provider. I have read the



above information and I understand and accept the terms and conditions of the above and I or my Guarantor will be responsible for the payment of my account.

Signature: _____

Date: _____

Please circle one: Patient / Guardian / Guarantor

Print Patient Name: _____

Print Guardian/Guarantor Name: _____



ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/CONSENT TO TREAT

By completing this form, you will help ensure payment to GOS for services under your health insurance policy or benefit plan.

Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in such telehealth visit and its recording, and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration, joint injections, and other procedures deemed necessary. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

I hereby assign to GOS my right to receive reimbursement for health care services provided to me and/or to any beneficiary under my health benefits plan and assign my legal claim to benefits under the plan, including but not limited to, my right to appeal and sue for each reimbursement and benefits. This assignment applies to all medical benefits, i.e., Medicare, private insurance, major medical benefits, Worker's Compensation, and any other health plans to which I or my beneficiary am entitled. I hereby authorize GOS to file claims with all such plans and carriers for services rendered to me and/or my beneficiary and further authorize and direct my insurance benefits to be paid directly to GOS. I understand and agree that, if a reimbursement check is made payable to GOS and me, that I promptly will take such action as requested by GOS to endorse the check so that GOS can be paid for services rendered.

I understand that I am financially responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no way releases me from this responsibility and imposes no obligation to GOS to collect money on my behalf.

I hereby authorize GOS to release to my insurer, health plan, and/or any authorized employee or agent of same such of my medical information and records necessary to ensure payment for services rendered.

I have read, understand, and agree to above. A photocopy of this agreement shall be considered as effective and valid as the original. This Assignment of Benefits will be effective until revoked by me in writing. Any revocation shall have a prospective effect only.

Patient's Name: _____
Patient/Guardian Signature: _____
Primary Insured's Signature (if different): _____
Patient's Social Security # (last four digits only): _____
Insurance Company: _____
Claim Number: _____
Date of Accident: _____
Date: _____



Acknowledgement

Date: _____

I acknowledge that I was provided with a copy of the Genesis Orthopaedic and Spine (GOS) Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print)

Personal Representative Signature

Relationship

For GOS use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgment of receipt of GOS's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

Employee Name

Date

This form should be placed in the patient's medical record



At Genesis – Orthopaedic and Spine (“GOS”), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by GOS, whether made by GOS personnel or your personal physicians and allied health practitioners. Your personal doctors and allied health practitioners may have different policies or notices regarding their use and disclosure of your medical information created in their offices or clinics.

This notice will tell you about the ways in which we may use and disclose medical information about you, referred to below as protected health information (“PHI”). We also describe your rights and certain obligations we have regarding the use and disclosure of PHI.

Uses and Disclosures for Treatment, Payment and Health Care Operations. GOS may use or disclose your PHI for the purpose of treatment, payment, and health care operations, described in more detail below, without obtaining written authorization from you. In addition, GOS and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

For Treatment. GOS may use and disclose PHI in the course of providing, coordination, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment. GOS may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, GOS may need to give PHI to your health plan in order to be reimbursed for the services provided to you. GOS may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. GOS may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. GOS may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration. GOS may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure GOS is complying with all applicable laws, and to help GOS continue to provide health care to its patients at a high level of quality. GOS may also disclose PHI to other health care providers and health plans for such entity’s quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance, provided that such entity has, or has had in the past, a relationship with the patient who is the subject of the information.

For Sharing PHI Among GOS and Its Medical And Allied Health Professional Staff. GOS and the physicians and other health care providers who are members of the GOS medical staff work together in an organized health care arrangement to provide medical services to you when you are a patient at GOS. GOS and the members of its medical staff will share with each other PHI that they collect from you at GOS as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients at GOS.

Other Uses and Disclosures for Which Authorization is not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, GOS may use and disclose PHI without your written authorization under the following circumstance:

As Required by Law and Law Enforcement. GOS may use or disclose PHI when required to do so by applicable law. GOS also may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.



For Public Health Activities and Public Health Risks. GOS may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. GOS may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. GOS may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye and Tissue Donation. GOS may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, GOS may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. GOS may use and disclose PHI, to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. GOS may use and disclose PHI of military personnel and veterans under certain circumstances. GOS may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the president or other authorized persons or foreign heads of state or to conduct special investigations.

Workers' Compensation. GOS may disclose PHI to comply with Workers Compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Fundraising Activities. Your PHI may be used to contact you in an effort to raise money for GOS. Your PHI may be disclosed to a foundation related to GOS. Such disclosure to contact information, such as your name, address and phone number and the dates you required treatment or services at GOS. The money raised in connection with these activities would be used to expand and support GOS's provision of health care and related services to the community. If you do not want to be contacted as part of these fundraising activities, please notify GOS marketing department in writing.

Appointment Reminders: Health-related Benefits and Services. Marketing: GOS may use and disclose your PHI to contact you and remind you of an appointment at GOS, or to inform you of treatment alternatives or other health-related benefits and services that maybe of interest to you, such as disease management programs. GOS may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to face communication or by giving you a promotional gift of nominal value.

Disclosures to You or for HIPAA Compliance Investigations. GOS may disclose your PHI to you or to your personal representative, and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. GOS must disclose your PHI to the Secretary of The United States Department of Health and Human Services ("The Secretary") when requested by the Secretary in order to investigate GOS's compliance with privacy regulations issued under the federal health Insurance Portability and Accountability Act of 1996("HIPAA")

Uses and Disclosures To Which You Have an Opportunity to Object. You will have the opportunity to object to these categories of uses and disclosures of PHI that GOS may make:

Disclosures to Individuals Involved in Your Health Care or Payment for Your Facility. Unless you object, GOS may disclose your PHI to a family member, other relative, friend or other person you identify as involved in your health care. GOS may also notify those people about your location or condition.



Other Uses and Disclosures of PHI For Which Authorization is Required. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations you have the right to revoke in writing.

Regulatory Requirements. GOS is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this notice. GOS reserves the right to change the terms of this notice and its privacy policies, and to make the new terms applicable to the entire PHI it maintains. Before GOS makes an important change to its privacy policies, it will promptly revise this Notice and post a new notice in the Admissions Areas. You have the following rights regarding your PHI:

You may request that GOS restrict the use and disclosure of your PHI. GOS is not required to agree to any restrictions you request, but if GOS does so it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from GOS be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing and sent to the responsible GOS Department Director. GOS will accommodate your reasonable request without requiring you to provide a reason for your request. Generally, you have the right to inspect and copy your PHI that GOS maintains, provided that you make your request in writing to the Medical Records Custodian. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), GOS will inform you of the extent to which your request has or has not been granted. In some cases, GOS may provide you a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, GOS may impose a reasonable fee to cover copying, postage, and related costs. If GOS denies access to your PHI, it will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If GOS does not maintain the PHI you request and if it knows where that PHI is located, it will tell you how to redirect your request. If you believe that your PHI maintained by GOS contains an error or needs to be updated, you have the right to request that GOS correct or supplement your PHI. Your request must be made in writing to the Medical Records Custodian, and it must explain why you are requesting an amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), GOS will inform you of the extent to which your request has or has not been granted. GOS generally can deny your request if your request relates to PHI : (i) not created by GOS; (ii) that is not part of the records GOS maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, GOS will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) If you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and GOS's denial attached; and (iii) complain about the denial. You generally have the right to request and receive a list of the disclosures of your PHI GOS has made at any time during the 6 years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosure for which you have provided a written authorization, and does not include certain used and disclosures to which this notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) for GOS's patient directory or to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. You should submit any such request to the Medical Records Custodian, and within (60) days of receiving your request (unless extended by an additional thirty (30) days), GOS will respond to you regarding the status of your request. GOS will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of \$10.00 finder's fee plus \$1.00 per page for each additional request. You have the right to receive a paper copy of this notice upon request. You may complain to GOS if you believe your privacy rights with respect to your PHI have been violated by contacting our Privacy Officer at 116 South Euclid Ave, Suite 1, Westfield NJ 07090 and submitting a written complaint. GOS will in no manner penalize you or retaliate against you for filing a complaint regarding GOS's privacy practices. You also have a right to file a complaint with the Secretary of the Department of Health and Human Services.



Notice of Nondiscrimination and Accessibility
DISCRIMINATION IS AGAINST THE LAW

Genesis Orthopaedic and Spine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Genesis Orthopaedic and Spine does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Genesis Orthopaedic and Spine provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Genesis Orthopaedic and Spine provides free language services to people whose primary language is not English, such as information written in other languages.

If you need these services, contact Genesis Orthopaedic and Spine Compliance Officer.

Name: Laura Chantre-Melicio

Mailing Address: 116 S. Euclid Ave, Suite 1, Westfield, NJ 07090

Phone: 908-588-2311

Fax: 908-588-2319

Email: manager@gsamedicine.com

If you believe that Genesis Orthopaedic and Spine has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Genesis Orthopaedic and Spine Compliance Officer. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Genesis Orthopaedic and Spine Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si usted habla español, le avisamos que tenemos servicios lingüísticos gratuitos a su disposición. Llame al: 1-212-606-1760, TTY: 1-800-676-3777.

注意：如果您講中文，可向您提供免費語言服務。致電 1-212-606-1760，TTY: 1-800-676-3777。

Внимание: Если Вы говорите по русски, примите к сведению, что Вы можете воспользоваться бесплатными услугами переводчика. Звоните по номеру: 1-212-606-1760, TTY: 1-800-676-3777.

ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis asistans nan lang ki disponib pou ou gratis. Rele nan 1-212-606-1760, TTY: 1-800-676-3777.

알려드립니다: 귀하께서 한국어를 하시는 경우, 무료로 언어 도움 서비스를 이용하실 수 있습니다. 1-212-606-1760 (TTY: 1-800-676-3777) 번으로 전화하십시오.

ATTENZIONE: se parli italiano sono disponibili servizi di assistenza linguistica gratuiti. Chiama il numero 1-212-606-1760, TTY: 1-800-676-3777.

1-212-606-1760 רופט אכטונג: אויב איר רעדט אידיש, זענען פאר אייך דא צו באקומען שפראך הילף סערוויסעס פריי פון אפצאל. TTY: 1-800-676-3777.
দৃষ্টি আকর্ষণ: যদি আপনি বাংলায় কথা বলেন, তাহলে আপনি বিনামূল্যে ভাষাগত সহায়তা পরিষেবা পেতে পারেন। ফোন করুন: 1-212-606-1760, TTY: 1-800-676-3777

UWAGA: Jeżeli mówi Pan/Pani po polsku, dostępne są dla Państwa bezpłatne usługi pomocy językowej. Proszę zadzwonić pod numer 1-212-606-1760, TTY: 1-800-676-3777.

ملاحظة: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات مساعدة لغوية بالمجان. اتصل على
1-212-606-1760، هاتف نصي (TTY): 1-800-676-3777.

VEUILLEZ NOTER: Si vous parlez français, des services d'assistance linguistique gratuits, sont à votre disposition. Appelez le 1-212-606-1760, TTY: 1-800-676-3777.

1- کریں کال ہیں دستیاب بلامعاوضہ (سروسز اسسٹنس لینگویج) سروسز والی کرنے فراہم معاونت میں زبان لیے کے آپ تو بے اردو زبان کی آپ اگر: فرمائیں توجہ
212-606-1760 TTY: 1-800-676-3777.

PAUNAWA: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-212-606-1760, TTY: 1-800-676-3777.

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, διατίθενται δωρεάν υπηρεσίες γλωσσικής βοήθειας για εσάς. Καλέστε το 1-212-606-1760. TTY: 1-800-676-3777.

VINI RE: Nëse flisni shqip, keni në dispozicion shërbime ndihme për gjuhën pa pagesë. Telefononi 1-212-606-1760, TTY: 1-800-676-3777.