

**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 Notice of Privacy Practices 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 your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**1. Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or 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 their 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.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Facility Directories:** Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician 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. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also 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 request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. 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 and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

## **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

## Office Policies & Fees

### **During Your Office Visit:**

- A picture ID and insurance card will be presented and scanned to your chart.
- We will collect a credit/debit card and our Card on File agreement will be completed.
- Co-pays are due at the time of visit and will be collected upon check in.
- Account balances will also be addressed, even if a statement hasn't been sent.
- For high deductible plans you will be asked for a deposit towards treatment at each visit.
- Out-of-network plans are considered private pay and will be collected in full at each visit.

### **Surgery Estimates:**

- Should your physician recommend surgery, you will be provided with an estimate for the surgeon fees. Any out of pocket costs will be requested in full as a deposit prior to the procedure.

### **Collection Accounts:**

- Any account sent to a collection agency will be withdrawn from any further care by any provider in this office.

### **Returned checks:**

- Returned checks will be assessed a \$25.00 fee for processing.

### **Insurance forms or disability forms:**

- All forms will have a \$20 fee for completion. These fees are due before the forms will be mailed/released and are not covered by your health insurance.

### **Copying of medical records:**

- PDF chart copies on a CD will be assessed a fee of \$15.00.
- \$10.00 per x-ray CD.
- You are able to access your records in your OnPatient account at no cost. (Not Xrays)

### **No Shows:**

- If you do not show for a scheduled appointment or notify the office 24 hours prior to your scheduled appointment, you will be subject to a \$50.00 fee per missed appointment. If you are new to our office the \$50.00 fee must be paid before we are able to schedule any further appointments.

### **Medication refills:**

- We require 24 hours to be completed. Please call your pharmacy first; they will submit the information to us directly.
- Refill requests will not be done on Friday, Saturday or Sunday, please plan ahead.

**I hereby agree that failure to adhere to the above office policies may result in dismissal from this medical practice.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)



## Credit Card on File Program & Agreement

Dear Patient,

We have a new policy we'd like to tell you about. As of **07/21/2025**, we implemented a policy requiring that a credit card be held securely on file for each of our patients.

As you know, the healthcare field has experienced some dramatic changes over the past few years, gone are the days of health insurance picking up the tab for all medical expenses. The result is increased patient deductibles, copays and co-insurance.

To make a payment more convenient for you, as well as to keep our billing costs down, we're putting into place a credit card on file program. If you've ever stayed in a hotel or rented a car, you are familiar with having a credit card on file. Here's how it works:

1. When you come in for your appointment, you'll simply pay your copay and deposit amount if applicable. Our office staff will ask you to provide a valid credit card which we will use the same methods to guard as we do your medical information. The credit card, debit card, health savings or flexible savings card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. It will **not** be kept at our office. Office staff will not have access to your card and only the last 4 digits of your card will show in our system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.
2. It will be on file only for future use. We will submit your claim to your insurance company; they will process the claim and send us and you an Explanation of Benefits (EOB). This will show what they covered and what your responsibility is. You typically receive the EOB before we do so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.
3. It will be used to collect the \$50 no show / same day cancellation fee per our policy. We will contact the patient before we charge this fee. Initial \_\_\_\_\_
4. Our practice will send you a **Text Message** that you have an amount due. You are able to pay the balance directly from that text with the card on file. If you want to use a different card, pay by check or discuss a payment plan you may still do so as long as you do so promptly.
5. We will send one statement to the OnPatient portal. **NO statements will be mailed.** If you have not established an OnPatient login, please do so.
6. After 30 days from notifying you, our practice will then charge your credit card, debit card, health savings or flexible spending card for the remaining balance your insurance company has determined that you owe. We will provide you a receipt to your OnPatient account when requested.

Rest assured, this program in no way hinders your ability to dispute a charge or question your insurance company about their determination of payment. We routinely review the accuracy of claims processed by insurance and will contact you if WE find a problem. But, if you find a problem, call us and we will help you investigate it. If we owe you money, we will refund to your card. Our direct billing telephone number is (916) 889-0977.

Thank you in advance for your understanding and cooperation with this new program. We look forward to continuing to meet your orthopaedic needs with the best care possible.

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By signing below, I authorize Folsom Orthopaedic Surgery & Sports Injury Medical Clinic, Inc. to store my signature and credit card information securely on-file and to charge my credit card for any outstanding balances when due.

If the credit card that I provide today changes, expires, or is declined for any reason, I agree to promptly provide Folsom Orthopaedic Surgery & Sports Injury Medical Clinic, Inc. with a new, valid credit card of which I will allow them to use for payment processing over the telephone. Even though Folsom Orthopaedic Surgery & Sports Injury Medical Clinic, Inc. is not processing in person, I agree that my updated card may be used with the same authorization as the original card presented.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT DEMOGRAPHICS		FOLSOM ORTHOPAEDIC SURGERY		
First Name	MI	Last Name		
Address				
City		ST	ZIP	
DOB / /	Marital Status	S	M	D
		W	Sex	M
				F
Primary Phone to reach you ( )			Other Number ( )	
Employer		Occupation		
May we leave information on your voice mail/machine? Yes No				
Who Referred you? Physician Family Friend Insurance Other				
Referring Physician's Name				
<b>In the event of an emergency please contact</b>				
Name		Relationship		Phone ( )
<b>Minor Patients</b> Name of Parent/Guardian				
Address if different from above				
Divorced or separated parents: It is our office policy that the parent accompanying the child for treatment will be held responsible for all bills; we cannot bill the other parent.				
<b>Insurance Information</b>				
<b>Primary Insurance</b>			Policy Holder Name	
Relationship to Insured	Self	Spouse	Child	Other
				Insured's DOB
ID#			Group#	
<b>Secondary Insurance</b>			Policy Holder Name	
Relationship to Insured	Self	Spouse	Child	Other
				Insured's DOB
ID#			Group#	
<b>IF YOUR INJURY IS JOB RELATED OR A PERSONAL INJURY, PLEASE SEE STAFF IMMEDIATELY</b>				

**NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:**

If we are filing an insurance claim for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your claim and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your health plan and the amount applied to you plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage based on your plan's determination of medical necessity will also be your responsibility. Your office visit co-pay is due at the time of the visit. If you have a deductible plan, we will collect a deposit towards your visit.

I assign and request payment of medical and surgical benefits to Folsom Orthopaedic Surgery & Sports Injury Medical Clinic, Inc. for services rendered. I hereby authorize said assignee to furnish information necessary to process my claim and to forward medical records for continuation of medical care. I understand that I am financially responsible for any unpaid balance within 30 days of my visit. A photocopy of this authorization shall be as valid as the original.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**CONSENT TO USE PROTECTED HEALTH INFORMATION &  
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Instructions / Rights of Patient**

1. Protected Health Information (“PHI”) may be used or disclosed to carry out treatment, payment or Health Care Operations.
2. You have the right to read and inspect the Notice of Privacy Practices for this health care facility prior to signing this form. The Notice of Privacy Practices may change at any time; therefore you should request and review a new Notice of Privacy Practices if you have not done so recently.
3. You have the right to place restrictions on how your PHI may be used or disclosed in the space provided below.
4. You have the right to revoke this Consent by sending a written notice, indicating the date and subject matter or other information that will reasonably identify this Consent.

**Consent for Release of Personal Health Information:**

I, the undersigned Patient or Representative, certify that I have read or otherwise understand this Consent and that I am legally competent to sign this Authorization on behalf of myself or the Patient. I authorize Folsom Orthopaedic Surgery to use or disclose the PHI to carry out treatment, payment or Health Care Operations.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Authorized Signature) (Date)

\_\_\_\_\_  
(Relationship to Patient)

I authorize you to speak with my adult family members or other individuals about my medical care as identified below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_