Henry DeGroot III, M.D. F.A.A.O.S.
Board Certified Orthopaedic Surgeon
2000 Washington Street
White Building, Suite 544
Newton, Massachusetts 02462
(617) 796-9922 fax: (617) 796-9923
on the web at www.drdegroot.com

Dear Patient,

Thank you for downloading the registration forms for your upcoming appointment with Dr. DeGroot. This packet includes all the forms you need. Please complete the registration form, the medical form, and sign the consent form and the receipt of privacy practices form at the end of this packet. Bring all 4 with you to your appointment. Dr. DeGroot will be able access information on the computer about your health in most cases - but he cannot do so until you give him permission via these forms. We apologize in advance for all the paperwork - the bulk of this packet is due to federal HIPAA regulations.

Included in this packet:

1) Registration form *(complete and sign)*
2) Medical history form *(complete and sign)*
3) Notice of privacy practices document *(for your information – no signature required)*
4) Consent for use of health information form *(signature required)*
5) Receipt of privacy practices form *(signature required)*

Your instructions for filling out these forms are as follows:

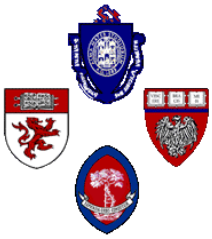
Please make sure to complete every section including addresses and dates of birth.

Please include your reason for seeing Dr. DeGroot on the Medical History form (i.e. right knee pain or left ankle sprain)

Please sign all four (4) forms.

Please remember to bring these forms to your appointment!

The Office of Dr. Henry DeGroot



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Patient Registration Form

PATIENT NAME:_____ SS#_____BIRTHDATE:_____

FIRST NAME MIDDLE NAME LAST NAME

ADDRESS _____

HOME PHONE:_____CELL:_____WORK PHONE_____EMAIL:_____

(EMAIL IS FOR PATIENT NOTIFICATION ONLY, AND IS NOT SHARED WITH ANY OTHER PERSONS OR ORGANIZATIONS)

CONTACT IN CASE OF EMERGENCY:

PARTNER'S NAME_____OTHER PERSON_____RELATIONSHIP:_____

HOME PHONE:_____ CELL: _____WORK PHONE: _____

PRIMARY CARE PHYSICIAN NAME:_____

TELEPHONE:_____FAX: _____

REFERRING PHYSICIAN NAME:_____

TELEPHONE:_____FAX: _____

PRIMARY INSURANCE COMPANY:

(Please note: For managed care plans, the patient is liable for the bill unless a PCP referral is on file with us today.) NAME:___

_____POLICY#:_____GROUP#_____

TELEPHONE NUMBER OF COMPANY:_____

POLICY HOLDER INFORMATION (***IF DIFFERENT FROM PATIENT***): NAME:_____

_____

SS# :_____DATE OF BIRTH:_____RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE:_____POLICY#:_____

ADDRESS_____TELEPHONE#:_____GROUP#_____

POLICY HOLDER INFORMATION (IF DIFFERENT FROM PATIENT):

NAME:_____

SS# :_____DATE OF BIRTH:_____RELATIONSHIP TO PATIENT:_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATIONS OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NECESSARYTO OBTAIN MEDICAL SERVICES.
I AUTHORIZE DR. DEGROOT TO RELEASE MY MEDICAL INFORMATION TO OTHER MEDICAL PROVIDERS, AS NEEDED FOR RADIOLOGY, PATHOLOGY, OR OTHER CONSULTATIONS THAT MAY BE RECOMMENDED.
I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS FROM OTHER INSTITUTIONS AND PROVIDERS TO DR. DEGROOT.
ASSIGNMENT OF BENEFITS: **I AUTHORIZE** PAYMENT OF MEDICAL BENEFITS DIRECTLY TO DR. HENRY DEGROOT FOR SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES INCLUDING REASONABLE ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF LACK OF REFERRAL OR DEFAULT.

SIGNED:_____DATE:_____

(parent should sign for patients under 18)

The Office of Dr. Henry DeGroot III, M.D.
2000 Washington Street, White Building Suite 544, Newton, Massachusetts 02462
www.drdegroot.com

MEDICAL HISTORY

Today's date:_____

Patient Name: _____ *Age*: _____ Occupation: _____

Describe your present problem: _____

Date symptoms first appeared or accident happened: _____

Please list all medications, supplements, and herbals you are actually taking:

Prescription meds: _____
_____

Herbals/non-prescription/supplements: _____

Do you have any allergies to medicines? No _____ If yes, please give reaction:

Yes – allergic to:_____ _____

Please describe your medical history (*please complete - we really need this information!*):

ALL your previous operations:_____

ALL your previous illnesses: _____

Date of hospitalizations: _____

Broken bones/fractures: _____

Do you smoke?_____ Have you quit smoking? _____ Do you use recreational drugs? Yes No

	Self	Family		Self	Family
Heart disease			Ulcers		
High blood pressure			Seizures or nervous disorder		
Chest pain or pressure (recently or in the past)			Easy or prolonged bleeding or bruising		
Stroke			Blood transfusion		
Any kind of diabetes			Blood clots / DVT		
Shortness of Breath			Kidney disease		
Emphysema			Prostate trouble		
Asthma /pneumonia			Bladder infection		
TB / HIV / hepatitis			Rheumatoid arthritis		
Osteoporosis			Gout (now or in the past)		
Thyroid trouble			High cholesterol		
Any kind of cancer			Other - please name		

Effective Date: April 14, 2011

The Office of Henry DeGroot III, M.D.

NOTICE OF PRIVACY PRACTICES

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

UNDERSTANDING YOUR HEALTH RECORD INFORMATION

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many healthcare professionals who contribute to your care. Understanding what is in your medical record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

We, at the Office of Henry DeGroot III, M.D. pledge to provide you with the highest quality of care and to build a relationship based on trust. This trust includes our commitment to respect the privacy and confidentiality of your health information.

This Notice of Privacy Practices is being given to you because federal law gives you the right to be told ahead of time about:

1. How Dr. DeGroot will handle your medical information;
2. What our legal duties are related to your medical information;
3. What your rights are with regard to your medical information;
4. A method for filing complaints about our privacy practices

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

When you need health care, you give information about yourself and your health to doctors, nurses, and other health care workers and staff. This information, along with the record of care you receive, is "protected health information" (or PHI). This information is kept an electronic form on our database.

(A) **The Office of Henry DeGroot III M.D. uses and discloses (shares) health information for many different reasons.** For some of these uses and disclosures, we will need to obtain prior written authorization (permission). However, we may legally use or disclose your health information for treatment, payment, and health care operations. We do not need to receive prior authorization for uses and disclosures described within the following categories:

For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories:

For treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose (share) medical information about you to other doctors and health care providers involved in your care. Example: A PCP may refer you to a specialist, such as a radiologist or a surgeon. The specialist may tell you that you need to be admitted to the hospital for treatment or surgery. All of the doctors in this example will share medical information about you. This is to coordinate care before, during, and after you go into the hospital.

For payment: We may use and disclose (share) your health information in order to bill and collect payment for the treatment and services provided you. Example: A bill may be sent to you or a third party payer. If you have health insurance, information on or accompanying the bill may include a portion of your health information that identifies you, as well as your diagnosis, procedures and supplies used for treatment. The insurance company uses the information to determine if you are eligible for benefits or if the services you received were medically needed for payment purposes. We may also provide your health information to our business associates, such as a billing company, claims processing companies and others that process our health care claims.

For health care operations: We may disclose (share) your health information for activities that are known as health care operations. These activities use health care information for the purpose of evaluating our performance and finding better ways to provide care. We may use your health information in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also share your health information with outside parties ("business associates") who perform services on behalf of Dr. DeGroot. These business associates must agree to keep your health information private. Examples of activities that make up health care operations include; legal counsel, transcription, storage, auditing, and consulting services.

(B) Other uses of your health information. Dr. DeGroot may use your health information to contact you about:

- ä scheduled appointments, registration/insurance updates, pre-procedure assessments or test results;
- ä information about patient care issues and treatment choices;
- ä other health-related benefits and services that may be of interest to you.

(C) We may disclose (share) your health information to others without your consent in certain situations. Example: If you need emergency treatment, or if you are unable to communicate with us (unconscious or in severe pain). In these situations we will try to get your consent. But, if you are unable to agree or disagree to consent and if we think you would consent if you were able to do so, we will disclose health information without consent.

(D) Other Specific Uses and Disclosures that DO NOT REQUIRE YOUR CONSENT.

(a) When disclosure of health information is required by federal, state, or local law, administrative or legal proceedings, health oversight activities, or by law enforcement: Examples of some required reporting include: health information about victims of abuse, neglect, domestic violence, or patients with gunshot and other wounds. In addition, we disclose health information when ordered in a legal or administrative proceeding.

(b) For public health activities: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. Example: we report information about births, deaths, and various diseases to the government officials in charge of collecting that data consistent with applicable law to carry out their duties.

(c) For business associates: There are some services provided in our practice through contracts with business associates. Examples include physical therapy, occupational therapy, home skilled nursing care, imaging services such as MRI, CT, and X-rays, lab work. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have requested them to do and, bill you or a third party payer for services rendered.

(d) For purpose of organ donation: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in procuring, banking, or transplantation of organs, eye or tissue

donation and transplants.

(e) For research purposes: In certain circumstances this practice may provide health information in order to conduct or participate in medical research. Your health information will only be used/or disclosed to researchers when their research has been approved by an Institutional Review Board (IRB). The IRB must have reviewed the research proposal, and established protocols to ensure the privacy of your health information. An example of this research would be to assess the outcomes of patients who had received specific therapy treatments.

(f) To avoid harm: In order to avoid a serious threat to the health or safety of a person or the public, we may provide health information to law enforcement personnel or persons able to prevent or lessen such harm.

(g) For specific government functions: We may disclose health information of military personnel and veterans in certain situations. And we may disclose health information for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

(h) For worker's compensation purposes: We may provide health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs.

(i) Appointment reminders and health-related benefits or services: We may use health information to provide appointment reminders or give you information about, treatment alternatives, or other health care services or benefits we offer.

The Uses and Disclosures Requiring You to Have the Opportunity to Object.

Disclosure to family, friends or others. The Office of Dr. DeGroot, using its best judgement, may disclose health information to a family member, friend, or other person that you indicate, unless you object in whole or in part, health information relevant to that person's involvement in your care or payment related to your care. The opportunity to get your authorization may be obtained retroactively in emergency situations.

(D) All Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections 1 (A) through (E), we will ask for your written authorization before using or disclosing any of your health information.

OUR LEGAL DUTIES TO PROTECT YOUR HEALTH INFORMATION

The Office of Henry DeGroot III M.D. is required by law to:

- Make sure that medical information that identifies you is kept private.
- Provide you with this notice that explains our privacy practices and how, when, and why we use and/or disclose (share) your health information.
- Follow the terms of the Notice currently in effect. However, we reserve the right to change our privacy policies and the terms of this notice at any time. Any changes will apply to the health information we already have. Before any important policy change goes into effect, we will change this Notice, the new Notice will be posted on our web site WWW.DRDEGROOT.COM and in a clearly visible location within our practice site(s) for public viewing.
- You may request a copy of this notice at any time from our Privacy Officer and you can view a copy of the notice on our Web site at WWW.DEGROOT.COM.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it, and the information it contains belongs to you. You have the right to:

(A) Request Limits on Uses and Disclosures of Your Health Information: You have the right to ask for restrictions on the use and disclosure (sharing) of your health information for treatment, payment or health care operations. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that are legally required or allowed to make.

(B) The Right to ask that Your Health Information Be Communicated to You in a Confidential Manner: You have the right to ask for your health information to be sent to you in different ways. For example you may ask for the Practice to contact you by mail rather than telephone, or only call at your home rather than at work. Your request must be in writing and explain the method of contact and location where your wish to be contacted. We will try to honor your request so long as we can easily provide it in the format you request.

(C) The Right to See and Get Copies of Your Health Information: In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request, in writing. We will respond within thirty (30) days from the receipt of your request. If you ask for a copy of your records, you will be charged a fee of $50. If your request is denied, we will inform you, in writing, our reasons for the denial and explain your right to have the denial reviewed. We may offer to give you a summary or explanation of the information your requested as long as you agree in advance to this and to any fees that this might cost. If you ask for information we do not have, but we know where it is, we must tell you where to direct your request.

(D) The Right to Receive an Accounting of Disclosures (a record of when and to whom, your health information was shared without your authorization). You have the right to obtain a list of the instances that we have shared your health information. You must make this request in writing. You may request as far back as six years, beginning April 14, 2003. The listing you get will include the date, name, and address (if known) of the person or organization receiving it. It will also include a brief description of the information given, a brief statement on why the information was shared, or a copy of the written request for the information.

The list will not include uses or disclosures that you have already consented to, such as those made for the treatment, payment, or health care operations, directly to you or your family. The list also will not include uses or disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

We have 60 days to respond to your written request. If we are not act on your request within the 60 days, we will notify you that we are extending the response time by 30 days. If we do that we will explain the delay in writing and give you a new date of when to expect a response. We will provide this list at no charge, but if you make more that one request in the same year, we will charge you $30 for each additional request.

(E) The Right to Correct or Update your Health Information. If you believe that there is a mistake in your health information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing.

We have 60 days to respond to your request. We may deny your request, in writing, if the health information is: (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your rights to file a written statement of disagreement with the denial. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future disclosures of your health information.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that the Office of Henry DeGroot III, M.D. may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may file a complaint with our Privacy Officer. You also may send a written complaint to either:

Office for Civil Rights
U.S. Department of health and Human Services
Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, Massachusetts 02203

Or:

Secretary of the Department of Health and Human Services
200 Independence Avenue
S.W. Washington, D.C. 20201
Or e-mail the HHS Secretary at HHS.MAIL@HHS.GOV

The Office of Henry DeGroot III, M.D. will take no retaliatory action against you if you file a complaint about our privacy practices.

PERSON TO CONTACT FOR INFORMATION

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of Health and Human Services, please contact our Privacy Officer, Meagan Wood via email at QUESTIONS@DRDEGROOT.COM or by phone at 781-237-9922.

The Office of Henry DeGroot III, M.D.

CONSENT for the Use and Disclosure of PROTECTED HEALTH INFORMATION

I understand that the doctors, nurses, administration staff, and other providers of health care who work with this practice, are called "providers". I understand that if I want to receive treatment from one or more of these providers, I need to give permission for them to share information about my health, among themselves and with other individuals for treatment and billing purposes and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by e-mail or facsimile.

By signing below, I agree that any of the providers associated with the Practice may:

1. Use my health information, on a need to know basis, to give me treatment.
2. Share my health information with others who are involved with my treatment either in or outside of this Practice.
3. Use my health information for billing reasons.
4. Share my health information with health insurance companies, government agencies, or other payors that request information related to benefits determination, claims filed for my visits and other billing matters.
5. Use my health information within the Practice and share it outside the Practice for health care operations including teaching, monitoring the quality of care and making improvements where needed, making sure providers are qualified (licensing, certification and credentialing), and carrying out other business and administrative activities.

I understand that the Practice has a Notice of Privacy Practices (the Notice) that describes in more detail how my health care information is used and shared with others. The Notice explains: (1) when I need to give further approval for the providers to use my health information or share it outside the practice and, (2) when my permission is not needed for the providers to use my health information or share it outside the practice (for example, if required by law, or as allowed for law enforcement purposes and legal proceedings, public health and health oversight activities, organ and tissue donations purposes, and certain approved research activities).

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this consent.

I understand that the Office of Henry DeGroot III, M.D. has reserved the right to change the Notice at any time and I may obtain a current copy of the Notice on their website www.drdegroot.com or by contacting the Privacy Officer at 617-796-9922.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST IN WRITING THAT PROVIDERS RESTRICT HOW MY HEALTH INFORMATION IS USED OR SHARED TO CARRY OUT TREATMENT, PAYMENT AND OTHER HEALTH CARE OPERATIONS AS DESCRIBED IN THE PRIVACY NOTICE. THE PROVIDERS ARE NOT REQUIRED TO AGREE TO MY RESTRICTIONS, BUT IF THEY DO, THE RESTRICTION IS BINDING.

I understand that I may revoke this consent, in writing, except to the extent that the providers have already acted on it. I also understand that if I revoke this consent, my providers have the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my health information as described above.

Patient's Signature_____Date _____

Print Name _____Date of Birth _____

When a patient is under 18, or is not competent to give consent, the signature of a parent, guardian, health care agent (proxy), or other legal representative is required.

Signature of Legal Representative: _____

Print Name/Relationship:_____Date _____

The Office of Henry DeGroot III, M.D.

ACKNOWLEDGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge the receipt of the **Notice of Privacy Practices** which provides me with detailed information about how the Office of Henry DeGroot III, M.D. may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

I also understand the if the Office of Henry DeGroot III, M.D. amends its **Notice of Privacy Practices**, I will be informed of the change and may obtain a copy of the revised Notice on their website at www.drdegroot.com or by contacting the Privacy Officer at (617) 796-9922.

I have the right to request, in writing, that the Office of Henry DeGroot III, M.D. restricts how they use and disclose my protected health information for the purposes of treatment, payment or health care operations and that the Practice is not required by law to grant my request. However, if the Practice does decide to grant my request, the Practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

Patient's Signature_____ _____Date _____

Patient Name_____ Date of Birth _____
(please print)

If patient is a minor, or is not competent to give consent, the signature of a parent, guardian, health care agent (proxy), or other legal representative is required.

Signature of Legal Representative: _____

Print Name: _____Date _____

Relationship of Representative to the patient:_____