NERVE, BONE & JOINT INSTITUTE

Restore. Regenerate. Reconstruct.
3 Washington Circle NW, #207/208
Washington, DC 20037
T: 202-955-6001 F:202-955-6008

Patient Name: **Age:**

Chief Complaint: Please describe what you are being seen for today:

What is your hand dominance (which hand do you write with)?
☐ Left ☐ Right ☐ Ambidextrous

Injury Type:
☐ Work Comp ☐ Car Accident ☐ Other

Work status:
☐ Currently working ☐ Retired ☐ Unemployed ☐ Disabled prior to injury ☐ Disabled due to injury

Occupation: ----------

Which of the following best describes your work related activities?

☐ Desk work ☐ Occasional lifting ☐ Light lifting ☐ Heavy lifting

At this moment, which of the following best describes your non-work related activities?

☐ Inactive ☐ Occasional sports ☐ Work out 2-3x per week ☐ Work out 4-5x per week

Are you receiving or filing any of the following with regard to your injury? ☐ Yes ☐ No

☐ Worker's compensation ☐ Disability ☐ Lawsuit

Date of injury or when problem began:

Is your problem the result of an injury? Yes ☐ No ☐

What caused your injury?

☐ Fall	☐ Reaching	☐ Collision/contact
☐ Lifting	☐ Fighting	☐ Pulling
☐ Throwing	☐ Twisting	☐ Other (specify):

Check any of the following that happened *at the time* of your injury: Felt

☐ Pain ☐ Heard popping ☐ Had swelling ☐ Dislocation ☐ Fracture ☐ Other (specify):

Check any of the symptoms you are currently experiencing:

☐ Pain ☐ Weakness ☐ Instability ☐ Restricted motion ☐ Other (specify):

If your problem is the result of an injury, where did it occur? (Check one answer only) ☐ N/A

☐ Home ☐ Work ☐ Motor vehicle accident ☐ Exercise ☐ Sport competition ☐ Other (specify):

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Have you received previous treatment for your current problem? If yes, please specify: ☐ Yes ☐ No

☐ Surgery	Describe:
☐ Injection	☐ Corticosteroid ☐ Hyaluronic acid ☐ Other (please describe):
☐ Physical therapy	PT duration:
☐ Prescription meds	Type and duration splinting:
☐ NSAIDs	Hand therapy duration:

Check the words that best describes the character of your pain today.	**What makes the pain better?**	**What makes your pain worse?**
☐ Aching ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Gnawing ☐ Penetrating ☐ Numb ☐ Sharp ☐ Tender ☐ Burning ☐ Exhausting ☐ Nagging ☐ Unbearable ☐ Other (specify):	☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Sitting ☐ Lying down ☐ Walking ☐ Standing ☐ Nothing in particular ☐ Other (specify):	☐ Sitting ☐ Standing ☐ Lying down ☐ Walking ☐ Exercising ☐ Activity in general ☐ Stopping/ bending ☐ Other (specify): ☐ Nothing in particular

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Allergies: Please list any allergies that you currently aware of

1.	2.
3.	4.

Medications: Please list any medications you are currently taking, both prescription and over the counter

1.	2.
3.	4.
5.	6.
7.	8.

Medical History: Please check all that apply

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Congestive heart failure
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Enlarged prostate
- ☐ GERD
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pacemaker/ AICD
- ☐ Peptic ulcer disease
- ☐ PVD
- ☐ Prostate cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Other:

Surgical History: Please check all that apply and specify the date for each. For previous arthroscopy, please indicate the type of surgery (e.g. meniscus repair, rotator cuff repair, etc). For joint replacement, please indicate which joint(s)

- ☐ Appendectomy: --------
- ☐ Arthroscopy: ----------
  Type: ----------
- ☐ Breast surgery: --------
- ☐ CABG: --------
- ☐ Cholecystectomy: --------
- ☐ Colon surgery: --------
- ☐ C-Section: --------
- ☐ Hernia repair: --------
- ☐ Hysterectomy: --------
- ☐ Joint replacement:
  Joint:
- ☐ Spine surgery: --------
- ☐ Tubal ligation: --------
- ☐ Other: : --------

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Family History: Please check whether a family member has had any of the following conditions

* **Note:** Maternal refers to your mother's side of the family; paternal refers to your father's side of the family

Relationship	Deceased (Yes/No)	Alzheimer's	Arthritis	Asthma	Cancer	Diabetes	Heart Disease	High Cholestero	Hypertension	Kidney Diseases	Mental Illness	Stroke	Substance Abuse	Thyroid Disease
Mother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐Y ☐N	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

Alcohol Use: ☐ Yes ☐ No

Drinks per week: please enter the number of drinks associated with each type of alcohol

Coffee Use: ☐ Yes ☐ No

Coffee consumption per week:

Drug Use: ☐ Yes ☐ No

If yes, please describe type:
(for example: marijuana, methamphetamines, steroids etc.)

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Tobacco Use (this refers to both present & past tobacco use): ☐ Yes ☐ No

If yes, describe type:

Frequency:

Quit date (if applicable):

Smokeless tobacco (this refers to both present and past smokeless tobacco use): ☐ Yes ☐ No

If yes, please describe type:

Frequency:

Quit Date (if applicable):

Review of Systems: In order to get a better understanding of your overall health, please check any of the following that you are *currently* experiencing

General	**Eyes**	**Gastrointestinal**	**Endo/Heme/Allergies**
☐ Fever	☐ Blurred vision	☐ Heartburn	☐ Easily bruise/bleed
☐ Chills	☐ Double vision	☐ Nausea	☐ Environmental allergies
☐ Weight loss	☐ Eye pain	☐ Vomiting	**Neurological**
☐ Fatigue	**Cardiovascular**	☐ Abdominal pain	☐ Dizziness
☐ Weakness	☐ Chest pain	☐ Diarrhea	☐ Tingling
Skin	☐ Palpitation	☐ Constipation	☐ Tremor
☐ Rash	☐ Shortness of breath	**Genitourinary**	☐ Seizures
☐ Itching	☐ Leg swelling	☐ Painful urination	☐ Loss of consciousness
Head, Eyes, Ears, Nose and Throat	**Respiratory**	☐ Urgency	**Psychiatric**
☐ Headaches	☐ Cough	☐ Frequency	☐ Depression
☐ Hearing loss	☐ Coughing up blood	**Musculoskeletal**	☐ Substance abuse
☐ Ear pain	☐ Mucus production	☐ Neck pain	☐ Nervous/anxious
☐ Congestion	☐ Shortness of breath	☐ Back pain	☐ Insomnia
☐ Sore throat	☐ Wheezing	☐ Joint pain	☐ Memory loss

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Authorization for Nerve Bone & Joint Institute PLLC

THE UNDERSIGNED PATIENT, OR AUTHORIZED INDIVIDUAL ACTING ON BEHALF OF THE PATIENT, UNDERSTANDS AND AGREES:

1. The physicians may administer medical care as necessary in the diagnosis and treatment of the patient.
2. The physicians are granted permission to release to the insurance company, employer or referring physician complete information regarding diagnosis and treatment.
3. I authorize payment of medical benefits directly to Nerve Bone & Joint Institute.
4. I understand and agree to pay all amounts as are or may become due for services rendered. I understand and agree that in the event full payment is not made on my behalf from any third party, this obligation shall be my responsibility.
5. I understand and agree to be personally responsible for any appearance at deposition or court by the physician.
6. I understand and agree that should my bill for any services rendered be referred to an attorney for collection, I am responsible for all court costs, service of process and an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting are considered reasonable by the undersigned.
7. I understand that my appointment time is reserved specifically for me. If I cannot make my appointment, NBJI asks for at least 24 hours notice of cancellation. If the appointment is not kept and at least 24 hours notice prior notice is not given, a charge of $100 may be incurred on my account.
8. I understand and agree that a 10% annual interest will be applied to any invoice balance that is outstanding for more than 30 days.
9. I understand that when allowed under state and federal law, NBJI reserves the right to balance bill me for the remainder of my unpaid balance.
10. I understand that NBJI reserves the right to charge a $30 fee for preparing and filling out all outside forms.

_____ Date _____

Patient, Parent/Guardian (please print)

_____(Seal)

Patient, Parent/Guardian Signature

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PRIMARY INSURANCE

Insurance Company: _____

Primary Insured Name: _____ Subscriber/Member ID#: _____

Group No/Enrollment Code: _____ Plan Name: _____

Relationship to Patient: _____ Self/Spouse/Child/Other :_____

SECONDARY INSURANCE

Insurance Company: _____

Secondary Insured Name: _____ Subscriber/Member ID#: _____

Group No/Enrollment Code: _____ Plan Name: _____

Relationship to Patient: _____ Self/Spouse/Child/Other:_____

THIRD INSURANCE

Insurance Company: _____

Third Insured Name: _____ Subscriber/Member ID#: _____

Group No/Enrollment Code: _____ Plan Name: _____

Relationship to Patient: _____ Self/Spouse/Child/Other:_____

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PATIENT EVALUATION FORM

NAME: _____ **Sex:**_____ **Date:** _____

Date of Birth:_____ **SSN:** _____

Height:_____**Weight:**_____**Marital Status:** **S**☐ **M**☐ **W**☐ **D**☐

Address:_____

City:_____**State:**_____**Zipcode:** _____

Home Phone:_____**Work**_____**Cell:**_____

Email: _____ **Fax:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Phone_____ **Phone:** _____

EMPLOYMENT INFORMATION

Employer Name: _____ Employer Phone: _____

Address:_____

City:_____**State:**_____**Zipcode:** _____

Home Phone:_____**Work** _____**Cell** __

EMERGENCY CONTACT

Contact Name: _____ Relationship to patient: _____

Address:_____

City:_____**State:**_____**Zipcode:** _____

Home Phone:_____**Work** _____**Cell** _____

NEXT OF KIN

Contact Name: _____ Relationship to patient: _____

Address:_____

City:_____**State:**_____**Zipcode:** _____

Home Phone:_____**Work:**_____**Cell:** _____

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If you have any questions or concerns regarding the following policies, please contact the main office staff. Thank you.

Phone: 202-955-6001 **Fax: 202-955-6008**

Work Slips:

Please discuss your current work status with your doctor prior to leaving the office. It is the patient's responsibility to advise the physician of his or her work status or intent to be out of work for any reason. Retro-active work slips will not be given.

Prescriptions:

Please address all prescription related questions before you leave the exam room. It is often difficult to interrupt the doctor once he has moved on to another patient's room.

MRI/CT Scans:

If at any time during your course of treatment you are given a prescription for an MRI or CT scan, please be aware of the following:

1. It is your responsibility to contact your insurance company to find out if you require prior authorization for this test and to subsequently contact our main office to inform us where you would like the test to be performed.

2. **If authorization is required**, it may take up to 1 ½ weeks in order for us to obtain authorization. Your insurance company requires clinical information (office notes, x-rays, or physical therapy reports) to be submitted for approval. The office notes are usually generated about 4 days after your visit to the office.

3. Once we have submitted the required information for authorization, please allow 3 to 5 days after for the insurance company to fax the authorization number to the office. We will contact you once this has been received by our office. If your approval is denied, you must contact your insurance company for further details.

4. After you have scheduled your MRI/CT scan, you will need to call our office to schedule a follow-up appointment. You will need your films/cd ready for your follow-up appointment with your doctor to discuss the results.

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Insurance

Please bring your insurance information with you to your appointment. All "co-pays" and "co-insurance" must be paid at the time of your visit. If your policy requires a referral, you must bring your referral with you in order to be seen the day of your appointment.

Worker's Compensation:

If you have been injured at work and have an open Worker's Compensation claim, please be advised that you must bring complete billing information to your visit, including the Worker's Compansation (WC) carrier, address, phone number, claim number, date of injury, adjuster's name and number. If you have an attorney, please provide us with his or her name, address, and contact information. Before we can schedule your appointment, we must have written authorization form your worker's compensation stating your visit with your doctor is approved. We cannot bill your private insurance for WC claims unless your claim has been settled or we have received a letter of denial from your WC carrier.

Nurse Case Managers:

If you wish to have your Nurse Case Manager present at the time of your appointment, you must notify our office at the time you make your appointment.

Signature:_____ Date:_____

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Notice of Privacy Practices

Our Obligation to You

We value the privacy of your medical information as an important part of our "patient first" pledge. We strive to use only the minimum amount of your health information necessary for the purposes described in this Notice. We collect information from you and use it to provide you with quality care, and to comply with certain legal requirements. We are required by law to maintain the privacy of your health information, and to give you this Notice of our legal duties, our privacy practices, and your rights. We are required to follow the terms of our most current Notice. When we disclose information to other persons and companies to perform services for us, we will require them to protect your privacy. There are other laws we will follow that may provide additional protections, such as laws related to mental health, alcohol and other substance abuse, and communicable disease or other health conditions.

This Notice covers the following sites and people: all health care professionals authorized to enter information into your chart, all volunteers authorized to help you while you are here, all our associates and on-site contractors, all departments and units within the hospital, all health care students, all health care delivery facilities and providers within the Nerve Bone & Joint Institute, and your personal doctor and others while they are providing care at this site. Your doctor may have different policies or notices about the health information that was created in his or her private office or clinic.

How We May Use and Disclose Your Health Information

Treatment: We may use and disclose your health information to provide treatment or services, to coordinate or manage your health care, or for medical consultations or referrals. We may use and disclose your health information among doctors, nurses, technicians, medical students, and other personnel who are involved in taking care of you at our facilities or with such persons outside our facilities. We may use or share information about you to coordinate the different services you need, such as prescriptions, lab work and imaging. We may give information to your health plan or another provider to arrange a referral or consultation.

Payment: We may use and disclose your health information so that we can receive payment for the treatment and services that were provided. We may share this information with your insurance company or third party used to process billing information. If you pay for your health care entirely out-of-pocket, you may request that we not share your information with your insurance company. We may contact your insurance company to verify what benefits you are eligible for, to obtain prior authorization, and to tell them about your treatment to make sure that they will pay for your care. We may disclose information to third parties who may be responsible for payment, such as family members, or to bill you. We may disclose information to third parties that help us process payments, such as billing companies, claims processing companies, and collection companies.

Healthcare Operations: We may use and disclose your health information as necessary to operate our facility and make sure that all of our patients receive quality care. We may use your health information to evaluate the quality of the services that you received, or the performance of our staff in caring for you. We may use your health information to improve our performance or to find better ways to provide care. We may use your health information to grant medical staff privileges or to evaluate the competence of our health care professionals. We may use your health information to decide what additional services we should offer and whether new treatments are effective. We may disclose information to students and professionals for review and learning purposes. We may combine our health information with information from other health care facilities to compare how we are doing and see where we can make improvements. We may use health information for business planning, or disclose it to attorneys, accountants, consultants, and others in order to make sure we are complying with the law. We may remove health information that identifies you so that others may use the de-identified information to study health care and health care delivery without learning who you are.

Health Information Exchanges: We may participate in health information exchanges to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we create about you with outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each of us can provide better treatment and coordination of your healthcare services.

Appointment Reminders and Service Information: We may use or disclose your health information to contact you to provide appointment reminders, or to let you know about treatment alternatives, or other health related services or benefits that may be of interest to you.

Individuals Involved In Your Care: We may give your health information to people involved in your care, such as family members or friends, unless you ask us not to.. We may give your information to someone who helps pay for your care. We may share your information with other health professionals, government representatives, or disaster-relief organizations, such as the Red Cross, in emergency or disaster-relief situations so they can contact your family or friends or coordinate disaster-relief efforts.

Research: We may use or disclose your health information for research that has been approved by one of our official research review boards, which has evaluated the research proposal and established standards to protect the privacy of your health information. We may use or disclose your health information to a researcher preparing to conduct a research project.

Public Health Activities: We may disclose your health information to public health or legal authorities whose official activities include preventing or controlling disease, injury, or disability. For example, we must report certain information about births, deaths, and various diseases to government agencies. We may disclose health information to coroners, medical examiners, and funeral directors as allowed by the law to carry out their duties. We may use or disclose health information to report reactions to medications, problems with products, or to

notify people of recalls of products they may be using. We may use or disclose health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

Serious Threat to Health and Safety: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. We will only disclose health information to someone reasonably able to help prevent or lessen the threat, such as law enforcement or government officials.

Required by Law, Legal Proceedings, Health Oversight Activities, and Law Enforcement: We will disclose your health information when we are required to do so by federal, state, and other law. For example, we may be required to report victims of abuse, neglect or domestic violence, as well as patients with gunshot and other wounds. We will disclose your health information when ordered in a legal or administrative proceeding, such as a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose health information to a law enforcement official to indentify or locate suspects, fugitives, witnesses, victims of crime, or missing persons. We may disclose health information to a law enforcement official about a death we believe may be the result of criminal conduct, or about criminal conduct that may have occurred at our facility. We may disclose health information to a health oversight agency for activities authorized by the law, such as audits, investigations, inspections, and licensure.

Specialized Government Functions: If you are in the military or a veteran, we will disclose your health information as required by command authorities. We may disclose health information to authorized federal officials for national security purposes, such as protecting the President of the United States or the conduct of authorized intelligence operations. We may disclose health information to make medical suitability determinations for Foreign Service.

Correctional Facilities: If you are an inmate or a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or law enforcement official. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.

Workers Compensation: We may disclose your health information as required by applicable workers compensation and similar laws.

Your Written Authorization: Other uses and disclosures of your health information not covered by this Notice, or the laws that govern us, will be made only with your written authorization. You may revoke your authorization in writing at any time, and we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

Your Privacy Rights Regarding Your Health Information

Right to See and Copy Your Health Record: You have the right to look at and receive a copy of your health record or your billing record. To do so, please contact the facility. You may be required to make your request in writing. If you would like a copy of your health record, a fee may be charged for the cost of copying or mailing your record, as permitted by law. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

Right to Update Your Health Record: If you believe that a piece of information is missing from your health record, you have the right to request that we add an amendment to your record. Your request must be in writing, and it must contain the reason for your request. To submit your request, please contact the Nerve, Bone, and Joint institute main number. We may deny your request to amend your record if the information being amended was not created by us, if we believe that the information is already accurate and complete, or if the information is not contained in records that you would be permitted by law to see and copy. Even if we accept your amendment, we will not delete any information already in your records.

Right to Request a Restriction on Certain Uses or Disclosures: You have the right to request that we limit how we use and disclose your health information. We are legally required to accept certain requests to not disclose health information to your health plan for payment or healthcare operations purposes if you have paid in full out of your own pocket for the item or service. We are not legally required to accept any other request for a restriction, but we will consider your request. If we do accept it, we will comply with your request, except if you need emergency treatment. Your request must be in writing.

Right to Choose How You Receive Your Health Information: You have the right to request that we communicate with you in a certain way, such as by mail or fax, or at a certain location, such as a home address or post office box. We will try to honor your request if we reasonably can. Your request must be in writing, and it must specify how or where you wish to be contacted. To submit a request, please contact the Nerve Bone & Joint Institute.

Changes To This Notice or Privacy Practices: We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we already have about you as well as any information we receive in the future.

NERVE, BONE & JOINT INSTITUTE

3 Washington Circle NW
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Washington, DC 20037

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Acknowledgement of Receipt for Notice of Privacy Practices

I, _____, have received a copy of the Nerve Bone &
Print Patient Name

Joint Institute PLLC Notice of Privacy Practices. I understand that if I have any questions or concerns, I may contact the Nerve Bone & Joint Institute at 202-955-6001.

_____ _____
Signature of Patient or Patient's Representative Date

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NBJI Confidential Communication Request Form

If it becomes necessary for NBJI to contact you by telephone, NBJI requires your written permission to leave detailed telephone messages on your voice mail system or with a person designated by you. If you would like NBJI to leave detailed messages on your voice mail system or with a designated person, please fill out the following form.

I, _____, **AUTHORIZE NBJI** to leave detailed telephone messages pertaining to my medical care at the following telephone numbers and/or persons. This will remain in effect until rescinded in writing.

Phone Number: ( ) _____ - _____

Other Number: ( ) _____ - _____

Home Answering Machine and/or Voice Mail ☐ YES ☐ NO

With Others (Specified names): _____

Email: _____

Signature _____ Date: ___/___/_____

This authorization may be cancelled at any time by instructing NBJI in writing mailed to 3 Washington Circle, Suite 207/208, Washington DC. 20037.

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HIPAA AUTHORIZATION FORM

This is an authorization for use or disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164).

Patient Full Name _____
(Please Print) Last Name, First Name, Middle Initial

Patient Date of Birth_____
Month/Day/Year

Patient Phone #_____ **Patient Email** _____

Address _____
Street

_____
City State Zip Code

I authorize Nerve, Bone, and Joint Institute to use and disclose the protected health information described below to _____ (individual seeking the information). This authorization for release of information covers the period of healthcare from: _____ to _____.

I authorize the release of my complete health record with the exception of the following information:

(☐) Mental health records
(☐) Communicable diseases (including HIV and AIDS)
(☐) Alcohol/drug abuse treatment
(☐) Other (please specify): _____

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

NERVE, BONE & JOINT INSTITUTE

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I am responsible for paying for any applicable materials, copying and/or mailing charges for the above requested medical records.

Please indicate how you would like to obtain this medical information.

(☐) I will pick up

(☐) Please mail to: _____

_____

(☐) Please fax to: _____

Signature of Patient:	**Date:**

After completion of this form, please fax, mail or hand-deliver a copy of the completed and singed document to our office.

NERVE, BONE & JOINT INSTITUTE

3 Washington Circle NW
Suite 207/208
Washington, DC 20037

Main: (202) 955-6001
Fax: (202) 955-6008

Expedited Medical Records Request

Instructions

All requests for medical records are normally processed within 30 days for requests received for records at the Washington, DC office and 15 days for requests received for records at the Virginia office. If you wish to receive your medical records more expeditiously, NBJI provides expedited service for non-medical emergency cases as follows:

(1) Two business days return via fax or by in-person pick-up for $100;
(2) Three business days return via fax or by in-person pick-up for $75; or
(3) Seven business days return via fax or by in-person pick-up for $25.

For expedited service, please complete and return to us the following:

(A) **Expedited Medical Records Request Form** (below);
(B) **HIPAA Authorization From** (found on NBJI website Patient portal); and
(C) **Fee for Expedited Service** *(Patients may pay for the expedited service fee by either completing the Credit Card Authorization Form available on the NBJI website or by mailing a check along with the completed form to NBJI).*

Please send the completed forms and payments to NBJI by email at patients@nerveboneandjoint.com, facsimile at (202) 955-6008 or mail at Nerve Bone and Joint Institute, 3 Washington Circle, N.W., Suite 207/208, Washington, D.C. 20037.

All requests for expedited service are processed from the date of receipt of the properly completed request forms and the required fees.

The expedited service fees do not include shipping and handling fees. Additional fees and delivery time may be applied if the records are mailed.

Please contact NBJI at (202) 955-6001 with any questions.

NOTE: For non-expedited service, please simply complete the HIPAA Authorization Form and return it to us. Copying and mailing fees may apply to non-expedited requests.

NERVE, BONE & JOINT INSTITUTE

3 Washington Circle NW
Suite 207/208
Washington, DC 20037

Main: (202) 955-6001
Fax: (202) 955-6008

Expedited Medical Records Request Form

Patient Name: _____
First Middle Last

Patient Address: _____

_____

Patient Telephone: _____ Date of Birth: _____

Email Address: _____

Attorney's/Representative's Name: _____
(If Applicable)

I hereby request that Nerve, Bone, and Joint Institute process my medical records expeditiously as follows: **(Please check one box)**:

- ☐ 24 hour return via fax or in person pick-up for $100
- ☐ 48 hours return via fax or in person pick-up for $75
- ☐ 1 week return via fax or in person pick-up for $25

I would prefer to: **(Please check one box)**:

- ☐ Personally pick-up the requested information from NBJI's Washington, DC Office. *(NBJI staff will provide you with a date and time of pickup)*.
- ☐ Fax the requested information to (_____)_____ to attention of: _____
- ☐ Have a copy of the requested information mailed to the following address **(Mailing fees may apply)**:

  _____

  _____

  _____

Signature of Patient: _____ Date: _____