# Tower Orthopaedics and Sports Medicine and Tower Orthopaedics Neurosurgical Spine Institute

Today's Date: _____ ☐Dr. Bakshian ☐Dr. Ganjianpour

## Patients Information

Patients Name: _____ Social Security Number: _____

Street Address: _____ City/State/Zip: _____

Date of Birth: _____ Height: _____ Weight: _____lbs.

Email: _____ Gender: ☐Male ☐Female ☐Non-Binary

Preferred Phone:_____ ☐Home ☐Mobile ☐Work Marital Status ☐S ☐M ☐D ☐W

Secondary Phone: _____ ☐Home ☐Mobile ☐Work

Employer:_____ Occupation:_____

Occupational Status: ☐Employed ☐Retired ☐Unemployed ☐Disabled

If Minor Contact Name:_____

## Emergency Contact

Contact Name:_____ Phone:_____

## Referral and Physician Information

Were you referred to Tower Orthopaedic and Sports Medicine by another physician? □Yes □No
If so, whom? _____

If not, how did you hear about us? ☐Internet ☐Patient ☐Family

Who is your primary care physician? _____

## Preferred Pharmacy - Per CMS guidelines we are required to use Electronic Prescription

Pharmacy Name:_____ Phone: _____

Street Address:_____ City/State/Zip:_____

## Demographic Data

**Race**: ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐Caucasian

☐Other Race ☐Unknown

**Language**: ☐Arabic ☐Armenian ☐Chinese ☐English ☐Farsi ☐French ☐Germ an ☐Haitian

☐ Hebrew ☐Hindi ☐Italian ☐ Japan ese☐ Korean ☐Polish ☐Portuguese ☐ Russian ☐Spanish ☐Other

**Ethnicity**: ☐Hispanic ☐Not Hispanic

## Healthcare Coverage

Mark the following sources of medical coverage that apply to you for this current pain complaint(s)

☐Private Insurance
☐Medicare
☐State Medicaid
☐ Worker's Compensation
☐ Self-Pay
☐ Automobile Insurance

## Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Group Number: _____ Policy/ I.D Number: _____

Insurance policy holder: ☐Self ☐Spouse ☐Child ☐Other

Complete this box if you are not the policy holder for your primary insurance.

Policy Holder Name: _____ Policy Holder Gender: ☐Female ☐Male

Street Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security Number: _____

Primary Telephone Number: _____ Employer: _____

## Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Group Number: _____ Policy/ I.D Number: _____

Insurance policy holder: ☐Self ☐Spouse ☐Child ☐Other

Complete this box if you are not the policy holder for your secondary insurance

Policy Holder Name: _____ Policy Holder Gender: ☐Female ☐Male

Street Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security Number: _____

Primary Telephone Number: _____ Employer: _____

## Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____ Agent Name: _____

Phone Number: _____ Fax Number: _____

Claim Number: _____ Date of Initial Injury: _____

## Patient Information

Your name: _____ Date of Birth: _____

Age: ___ Dominant Hand: ☐R ☐L Height:_____ Weight:_____ lbs.

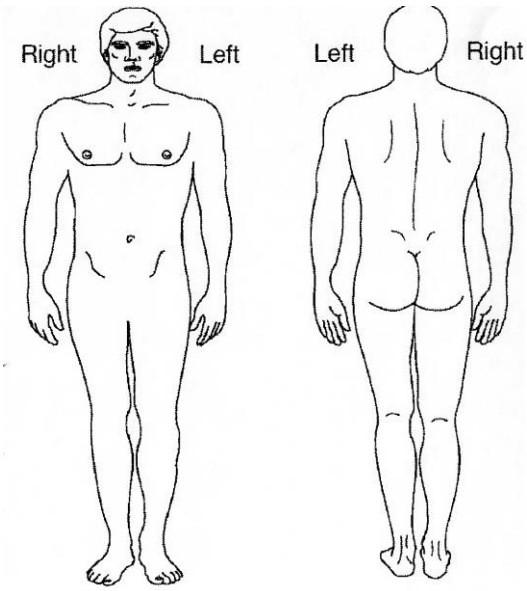
## Pain Diagram

Primary Complaint for which you are here today? _____

Body Part? _____

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A"= aching




Where is your worst pain located? _____

Does this pain radiate? If so, where? _____

## Pain Description

Check all applicable symptoms associated with your pain:

| | | | |
|---|---|---|---|
| ☐Aching | ☐Weakness | ☐Shooting (Where?): _____ | ☐Clicking |
| ☐Cramping | ☐Locking/Catching | ☐Spasming | ☐Stabbing/Sharp |
| ☐ Hot/Burning | ☐Numbness/Tingling | ☐Swelling | ☐Instability |

What word best describes the frequency of your pain? ☐Constant ☐ Intermittent

When is your pain at its worst? ☐During the day ☐Evenings ☐ Middle of the night ☐Mornings

## Onset of Symptoms

Did your problem result from a specific injury? ☐No ☐Yes, Date of Injury: _____

Can you describe the injury that caused the symptoms for which you are here today?

_____

_____

Since your pain began, how has it changed? ☐Decreased ☐Increased ☐Stayed the same

If no specific injury, how did the problem start?

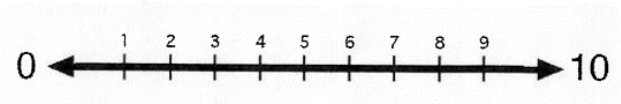
_____

## Pain Scale

Use the pain scale described below to rate your pain for the questions below:

0.Pain Free

1. Very Minor annoyance, occasional minor twinges
2. Minor annoyance, occasional strong twinges
3. Annoying enough to be distracting
4. Can be ignores if you are really involved in toy work/task, but still distracting
5. Cannot be ignored for more than 30 minutes
6. Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7. Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8. Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9. Unable to speak, crying out or moaning uncontrollab
10. Unconscious, pain makes you pass out




___ What number on the pain scale (0-10) best describes your pain **right now**?

____ What number on the pain scale (0-10) best describes your **worst pain**?

___ What number on the pain scale (0-10) best describes your **Least pain**?

____ What number on the pain scale (0-10) best describes your **average pain over the last month**?

## Mark all of the following activities that are adversely/negatively affected by your pain

☐Enjoyment of life
☐General Activity
☐ Mood
☐Normal Work
☐Recreational activities
☐ Relationship with people
☐Sleep
☐Walking
☐ Other: _____

## Describe the effect of each of the following on your pain

What makes your pain better?

_____

What makes your pain worse?

_____

## Other Doctors Consulted

Mark the following physicians or specialists you have consulted for treat men t of your current pai n problem(s).

(ONLY FOR PAINRELIEF; NOT FOR OTHER PROBLEMS) ☐None (Please skip this section if this box is checked)

☐Acupuncturist
☐Chiropractor
☐ Neurologist
☐Orthopedic Surgeon
☐General Physician
☐Internist
☐ Rheumatologist
☐Podiatrist
☐Pain Physician
☐Physical Therapist
☐ Neurosurgeon

☐ Other (Please list other MD names): _____

## Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

☐I HAVE NOT HAD ANY INTERVENTIONAL PROCEDURES PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

☐ MRI of the _____ Date: _____

☐X-ray of the _____ Date: _____

☐ CT scan of the _____ Date: _____

☐Other diagnostic testing: _____ Date: _____

## Interventional Pain Treatment History

Mark all of the following interventional pain you have undergone prior to today's visit:

☐ I HAVE NOT HAD ANY INTERVENTIONAL PROCEDURES PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

☐ Facelift Injections _____Date: _____

☐Discogram - (circle all levels that apply) Cervical /Thoracic/ Lumbar _____ Date: _____

☐ Epidural Injection _____Date: _____

☐ Joint Injection - Joint (s )_____Date: _____

☐ Trigger Point Injection -Area _____ Date: _____

☐Other: _____ Date: _____

## Past Medical History - Diagnosed Problems Only

**General Medicine**

☐Cancer- Type: _____

☐Diabetes – Type: _____

**Respiratory**

☐Asthma

☐Bronchitis

☐Emphysema/ COPD

☐Pneumonia

☐Tuberculosis

**Gastrointestinal**

☐Bowel Incontinence

☐GERD (Acid reflux)

☐Gastrointestinal Bleeding

☐Constipation

**Genitourinary/Nephrology**

☐Bladder Infection(s)

☐Dialysis

☐Kidney Infection(s)

☐Kidney Stones

☐Anemia

☐Urinary Incontinence

**Infection**

☐Hepatitis A (Active/inactive/unsure)

☐Hepatitis B (Active/inactive/unsure)

☐Hepatitis C (Active/inactive/unsure)

☐HIV

**Head/Eyes/Ears/Nose/Throat**

☐Headaches

☐Migraines

☐Head injury

☐Hyperthyroidism

☐Hypothyroidisms

☐Glaucoma

**Cardiovascular**

☐Heart Attack
☐High blood pressure
☐High Cholesterol
☐Mitral Valve Prolapse
☐Murmur
☐Phlebitis
☐Poor Circulation
☐Stroke
☐Coronary Artery Disease

**Musculoskeletal**

☐Carpal Tunnel Syndrome
☐Chronic Low Back Pain
Chronic Neck Pain
☐Chronic Joint Pain
☐Fibromyalgia
☐Joint Injury
☐Osteoarthritis
☐Osteoporosis
☐Rheumatoid arthritis
☐Vertebral Compression
☐Fracture
☐Gout

**Neuropsychological**

☐Alcohol Abuse
☐Alzheimer Disease
☐Bipolar Disorder
☐Depression
☐Epilepsy
☐Prescription Drug Abuse
☐Multiple Sclerosis
☐Paralysis
☐Peripheral Neuropathy
☐Seizures
☐Relfex Sympathic Dystrophy/CRPS
☐Anxiety
☐Claustrophobia

Other Diagnosed Conditions:

_____

Do You Have the Following Devices:

☐Pacemaker
☐Spinal Cord Stimulator
☐Pain Pumps
☐STENT(S)
☐Embedded Defibrillator
☐Any metallic object embedded in any part of your body, if so: which part of your body? _____

## Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

☐I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE. (Leave this section blank if this box is checked)

**Abdominal Surgery**

☐Gallbladder Removal _____

☐Appendectomy_____

☐Other_____

**Female Surgeries**

☐Caesarean Section _____

☐Hysterectomy_____

☐Ovarian _____

☐Other_____

**Heart Surgery**

☐Valve Replacement _____

☐Aneurysm Repair _____

☐STENT placement _____

☐Other_____

**Joint Surgery**

☐Wrist _____

☐Ankle _____

☐Shoulder _____

☐Hip_____

☐Knee _____

**Spine/Back Surgery**

☐Discectomy (levels) _____

☐Laminectomy _____

☐Spinal Fusion (levels) _____

**Other common Surgeries**

☐Hemorrhoid Surgery _____

☐Hernia Repair _____

☐Thyroidectomy _____

☐Tonsillectomy_____

☐Vascular Surgery _____

☐Cosmetic Surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary)

_____

_____

_____

_____

_____

## Anesthesia History

Mark the following statement that describes your history with anesthesia:

☐ I have never had anesthesia (no surgery requiring sedation).

☐ I have had anesthesia previously WITH AN ADVERSE REACTION FROM:

☐Local Anesthesia ☐Epidural ☐General Anesthesia ☐Medication IV

Please Explain:_____

☐ I have a family history of adverse reaction to anesthesia from:

Please Describe:_____

## Current Medications

Please list all medications you are currently taking. Attach an additional sheet, if required.

**Are you currently taking any blood-thinners or anticoagulants? ☐ Yes Name: _____ ☐ No**

**Are you currently taking Ozempic or similar medicines? ☐ Yes Name: _____ ☐ No**

| Medication Name | Dose and Frequency | Medication Name | Dose and frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Allergies

Please list all medications you are allergic to.

| Medication Name | Allergic Reaction Type | Medication Name | Allergic Reaction Type |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Topical Allergies: ☐Iodine ☐Latex ☐Tape Are you allergic to shellfish? ☐Yes ☐No**

## Personal Injury or work-related accident Information

Complete this section **only** if your pain is a result of a personal injury accident or injured at work.

My pain is caused by ☐A work-related injury ☐An automobile accident ☐Other accident

1. Following the accident I
   - ☐Was taken to the hospital by ambulance
   - ☐Was taken to the hospital by Care Flight
   - ☐Went for treatment the same day
   - ☐ First went for treatment on or about _____

2. LEGAL ACTION: Complete the following that apply to your accident/injury:

☐I have hired an attorney for this case, Name of the attorney: _____

☐My case is currently in litigation

☐My case is closed and no longer in litigation.

***For motor vehicle accidents, please complete questions 3 - 6 .***

3. I was ☐Not wearing my seatbelt ☐Wearing my seatbelt
4. I was the ☐Back seat passenger ☐Front seat passenger ☐Driver
5. The vehicle was struck ☐Fron behind ☐From the front ☐From the left side ☐From the right side
6. The airbags ☐Deployed ☐Did Not deployed

## Social History

Marital status: ☐Divorced ☐Domestic Partner ☐Married ☐Single ☐Widowed

Highest level of education obtained: ☐Grammar School ☐High School ☐College ☐Post-Graduate

Alcohol Use: ☐Never Drinks Alcohol ☐History of Alcoholism ☐Drinks Alcohol Socially (How many Glasses?) : _____ ☐Current Alcoholism

Tobacco Use: ☐Current Tobacco User ☐ Former Tobacco User ☐Has Never User Tobacco

Do you have a history or addiction to any narcotic or prescription medications?

☐Yes (which one?):_____ ☐No

Current Occupation and name of the employer:_____

## Family History

| | Mother | Father |
|---|---|---|
| Arthritis | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ |
| Liver Problems | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Stroke | ☐ | ☐ |

Other medical problems:_____

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY

☐I AM ADOPTED (NO MEDICAL HISTORY AVAILABLE).

## Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History (page 7) ☐None (Please skip this section if this box is checked)

**Constitutional:**
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Easy Bruising
- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Fatigue
- ❑ Fevers
- ❑ Insomnia
- ❑ Low Sex Drive
- ❑ Night Sweats
- ❑ Tremors
- ❑ Unexplained Weight Gain
- ❑ Unexplained Weight Loss
- ❑ Weakness

**Eyes:**
- ❑ Recent Visual Changes

**Ears/Nose/Throat/Neck:**
- ❑ Dental Problems
- ❑ Earaches
- ❑ Hearing Problems
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

**Cardiovascular:**
- ❑ Bleeding Disorder
- ❑ Chest Pain
- ❑ Deep Vein Thrombosis
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Lightheadedness
- ❑ Shortness of Breath During Sleep
- ❑ Swelling in the Feet

**Respiratory:**
- ❑ Cough
- ❑ Wheezing
- ❑ Pulmonary Embolism
- ❑ Shortness of Breath on Exertion/Effort
- ❑ Shortness of Breath at Rest

**Gastrointestinal:**
- ❑ Abdominal Cramps
- ❑ Acid Reflux
- ❑ Constipation
- ❑ Coffee Ground Appearance in Vomit
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Hernia
- ❑ Vomiting

**Musculoskeletal:**
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Muscle Spasms
- ❑ Neck Pain

**Genitourinary/Nephrology:**
- ❑ Blood in Urine
- ❑ Decreased Urine Flow/Frequency/Volume
- ❑ Flank Pain
- ❑ Painful Urination

**Neurological:**
- ❑ Carpal Tunnel Syndrome
- ❑ Dizziness
- ❑ Headaches
- ❑ Numbness/Tingling
- ❑ Instability When Walking
- ❑ Tremors
- ❑ Seizures

**Psychiatric:**
- ❑ Depressed Mood
- ❑ Feeling Anxious
- ❑ Stress Problems
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

**Doctor's Signature**:_____

## Consent for Treatment

I authorize Tower Orthopaedics and any associates, assistants and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Signed:_____ Date: _____

## Medication History Consent

A medication history is a list of medicines that Tower Orthopaedics and other doctors have recently prescribed for a patient . It is collected from a variety of sources, including a patient's pharmacy, health plans, and other healthcare providers.

I give my consent for Tower Orthopaedics to retrieve and review my medication history. I understand that this will become part of my medical record.

Signed:_____ Date: _____

## Privacy Practices and Consent to Release Protected Health Information

The Notice of Privacy Practices for Tower Orthopaedics is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge I have had the opportunity to review the Notice of Privacy Practices.

I authorize Tower Orthopaedics to release my Protected Health Information (medical records) to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Tower Orthopaedics that Tower Orthopaedics will not release my Protected Health Information to any other party without expressed consent.

Signed:_____ Date: _____

## Medicare Release

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT:

I request that payment under the medical insurance program be made on my behalf to Tower Orthopaedics for any services furnished me by its physician (s) and/or practitioners. I authorize any holder of medical information about me to release to my healthcare insurance (Medicare) and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed:_____ Date: _____

**Tower Orthopaedics and Sports Medicine**

**Medicare Authorization of Benefits**

**Signature on File**

Patient Name:_____
Please print

I request that payment of authorized Medicare benefits be made payable to **Mark Ganjianpour, M.D. and/or Tower Orthopaedics and Sports Medicine** physician for any services furnished to me by the physician and/or group. I authorize any holder if medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services.

Patients Signature:_____ Date: _____

**MEDIGAP ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medigap benefits be made payable **to Mark Ganjianpour, M.D. and/or Tower Orthopaedics & Sports Medicine** for any services furnished to me by the physician and/or group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services.

Patients Signature:_____ Date: _____

**Other Insurance**

I hereby authorize payment of my medical and surgical Insurance benefits to **Mark Ganjianpour M.D. and Tower Orthopaedics and Sports Medicine**. I understand I am financially responsible for any and all charges whether or not paid by said insurance. If co-payment and/or deductible are designated by my insurance company or health plan, I agree to pay them **to Mark Ganjianpour, M.D. and/or Tower Orthopaedics and Sports Medicine**. I authorize **Mark Ganjianpour, M.D. and/or Tower Orthopaedics and Sports Medicine** to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Patients Signature:_____ Date: _____

# DISCLOSURE OF FINANCIAL INTEREST

I have been advised and understand that Dr. Mark Ganjianpour has interest in Linden Surgery Center, and that he may have a financial interest in one or more companies that provide surgical implants or other health care services that have been prescribed for me. However, I also understand that Dr. Ganjianpour does not choose medical facilities or surgical implants based upon such financial interests. I acknowledge and understand that I have the right to choose any hospital, physician or health care provider that I want for the services that have been prescribed for me, and that I am knowingly and voluntarily choosing Dr. Ganjianpour and Linden Surgery Center. I have been advised that if I have any complaints regarding the medical care that I receive, I can contact the California Medical Board at (916) 263-2382 and/or the California Department of Public Health at (916) 445-4171.

_____ _____

Signature Date

_____

Print Name

Tower Orthopedics and Sports Medicine
6330 San Vicente Blvd. Ste. 310
Los Angeles, CA 90048
(310) 855-0751 (310) 657-6342 Fax

# Authorization for release and/or disclosure of medical information

Medical Information Request **from:**

_____
**Name of provider or Facility**

_____
Address

_____ _____
Telephone Fax

**Please** Send Medical Information **to:**

_____
**Name of provider or Facility**

_____
Address

_____ _____
Telephone Fax

**I hereby authorize _____to release and/or disclose the medical information as indicated below to the health provider or facility indicated above.**

Release and/or Disclose records and information regarding:

_____ _____ ___-___-____
Name of patient Medical records# Date of birth

_____ (___)_____
Address Telephone #

**Duration:** This Authorization shall become effective immediately and shall remain in effect until revoked in writing by the undersign.

**Revocation:** the authorization may be revoked in writing by the undersign at any time before the release of any information from the disclosing party. Written revocation will not affect any action taken in reliance on the authorization before the revocation was received.

**Redisclosure:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**Records Requested:**

Medical Records… Complete Chart… Or From _____To_____
X-Rays M.R.I. Other_____ Report Films

**A copy of this authorization is as valid as the original.** **Date: _____**

**I have the right to receive a copy of this authorization. The copy is for me to keep.**

Tower Orthopaedics and Sports Medicine

6330 San Vicente Boulevard, Suite 310, Los Angeles, CA 90048

Telephone: 310-855-0751 Fax: 310-657-6342

# ***Notice of Privacy Practices***

## To our patients:

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

## Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

## Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Practice Administrator/Privacy Officer, 6330 San Vicente Boulevard, Los Angeles, CA 90211, or you may call 310-855-0751 for further information.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Tower Orthopaedics and Sports Medicine, Practice Administrator/Privacy Officer, 6330 San Vicente Boulevard, Suite 310, Los Angeles, CA 90048, for any questions you may call us at 310-855-0751. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Practice Administrator/Privacy Officer, 6330 San Vicente Boulevard, Suite 310, Los Angeles, CA 90048, or you may call 310-855-0751. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Practice Administrator/Privacy Officer, 6330 San Vicente Boulevard, Suite 310, Los Angeles, CA 90048, or you may call 310-855-0751 to contact for further information.

I hereby acknowledge that I have been presented with a copy of (name of practice's) Notice of Privacy Practices.

Patients Signature:_____ Date: _____

Name of the Patient:_____

hereby acknowledge that I have been presented with a copy of Tower Orthopaedics and Sports Medicine Notice ·of Privacy Practices.

Date: _____

Name of the Patient:_____

# NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

## NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

| | |
|---|---|
| _____ | _____ |
| Date | Patient's Name (Type or Print) |
| | _____ |
| | Patient's Signature |
| _____ | _____ |
| Date | Patient Representative's Name and Relationship (Type or Print) |
| | _____ |
| | Patient's Representative's Signature |

Original to be maintained in patient's medical records.