



Patient / Insurance Information

Patient Name: Mr. Mrs. Ms. _____

Address: _____
Street City State Zip

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Email Address: _____

SS #: _____ Driver's Lic #: _____

Date of Birth: _____ Marital Status: S M D W

How did you hear about Advanced Arm Dynamics? Internet Newspaper/Magazine Patient referral Dr referral

Will you need an interpreter? Yes No If so, what language? _____

Emergency Contact (EC): Mr. Mrs. Ms. _____

EC Address: _____
Street City State Zip

EC Relationship: _____ EC Work Phone #: _____

EC Home Phone #: _____ EC Cell Phone #: _____

Employer: _____ Work related injury? Y N

Employer's Address: _____
Street City State Zip

Currently Employed? Yes No Employer's Phone #: _____

Referring Physician: _____

Physician's Address: _____
Street City State Zip

Physician's Phone #: _____ Physician's Fax#: _____

Primary Care / Family Physician: _____

Physician's Address: _____
Street City State Zip

Physician's Phone #: _____ Physician's Fax#: _____

Date of Injury: _____ Which side: Left Right

Diagnosis: _____

Location accident occurred: _____

Please describe your accident _____



Patient / Insurance Information

Case Type: Worker's Comp Indemnity Private Pay Voc. Rehab
 Medicare VA HMO Medicaid DARS

Primary Insurance Information

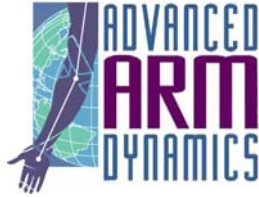
Insurance Carrier: _____
Insurance Address: _____
Street City State Zip
Case Manager: Mr. Mrs. Ms. _____
Insurance Phone #: _____ Insurance Fax #: _____
Insured's Name: _____ Group Policy/ID#: _____
Insured's SS#: _____ Insured's ID#: _____
Relationship to Patient _____ Insured's DOB: _____

Secondary Insurance Information

Insurance Carrier: _____
Insurance Address: _____
Street City State Zip
Case Manager: Mr. Mrs. Ms. _____
Insurance Phone #: _____ Insurance Fax #: _____
Insured's Name: _____ Group Policy/ID#: _____
Insured's SS#: _____ Insured's ID#: _____
Relationship to Patient _____ Insured's DOB: _____

Workers Compensation Information

Date of Accident: _____ Has employer been notified? Yes No
Employer at injury date: _____
Employer's Address: _____
Street City State Zip
Insurance Carrier: _____
Insurance Address: _____
Street City State Zip
Insurance Phone #: _____ Insurance Fax #: _____
Claim Rep/Adjustor: Mr. Mrs. Ms. _____
Claim Rep's Phone #: _____ Claim Rep's Fax #: _____
Claim Rep's Email Address: _____ Claim #: _____



Assignment of Benefits

- I authorize medical benefits be paid directly to Advanced Arm Dynamics.
- I authorize Advanced Arm Dynamics to release any medical information concerning my treatment to my physician, insurance carrier, and upper extremity specialists.
- I authorize the staff of Advanced Arm Dynamics to perform prosthetic procedures as deemed necessary by the prosthetist and prescribed by my physician.
- I understand that I am financially responsible for any and all charges and fees not covered by my insurance.

Patient Signature

Date

Patient Name (please print)

Parent or Guardian Signature (if applicable)

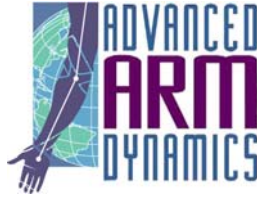
Date

Parent or Guardian Name (please print)

AAD Representative Signature

Date

AAD Representative Title



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 IT CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Advanced Arm Dynamics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
 - The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Advanced Arm Dynamics Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting 800-323-6422.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Advanced Arm Dynamics
123 W Torrance Blvd., Suite 203
Redondo Beach, CA 90277

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This Notice is effective on or after April 14, 2003.

Complaints

As listed below, health information privacy complaints may be filed with the Secretary of DHHS and should be addressed to him at the OCR (Office for Civil Rights) regional office that is responsible for matters relating to the Privacy Rule arising in the state or jurisdiction where the covered entity is located. Complaints may also be filed via email at the address noted below.

Where to File Complaints Concerning Health Information Privacy

For complaints involving entities located in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, or Vermont:

Region I, Office for Civil Rights, US Department of Health and Human Services, Government Center, JFK Federal Building--Room 1875, Boston, MA 02203. Voice phone (617) 565-1340. FAX (617) 565-3809. TDD (617) 565-1343.

For complaints involving entities located in New Jersey, New York, Puerto Rico, or the Virgin Islands:

Region II, Office for Civil Rights, US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza--Suite 3312, New York, NY 10278. Voice phone (212) 264-3313. FAX (212) 264-3039. TDD (212) 264-2355.

For complaints involving entities located in Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, or West Virginia:

Region III, Office for Civil Rights, Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. Main Line (215)861-4441. Hotline (800)368-1019. FAX (215) 861-4431. TDD(215)861-4440.

For complaints involving entities located in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, or Tennessee:

Region IV, Office for Civil Rights, US Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsythe Street SW, Atlanta, GA 30303- 9809. Voice phone (404) 562-7886. FAX (404) 562-7881. TDD (404) 331-2867.

For complaints involving entities located in Illinois, Indiana, Michigan, Minnesota, Ohio, or Wisconsin:

Region V, Office for Civil Rights, Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice phone (312) 886-2359. FAX (312) 886-1807. TDD (312) 353-5693.

For complaints including entities located in Arkansas, Louisiana, New Mexico, Oklahoma or Texas:

Region VI, Office for Civil Rights, Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Voice phone (214) 767-4056. FAX (214) 767-0432. TDD (214) 767-8940.

For complaints involving covered entities located in Iowa, Kansas, Missouri, or Nebraska:

Region VII, Office for Civil Rights, Department of Health and Human Services, 601 East 12th Street--Room 248, Kansas City, MO 64106. Voice phone (816) 426-7278. FAX (816) 426-3686. TDD (816) 426-7065.

For complaints involving covered entities located in Colorado, Montana, North Dakota, South Dakota, Utah, or Wyoming:

Region VIII, Office for Civil Rights, Department of Health and Human Services, 1961 Stout Street--Room 1185 FOB, Denver, CO 80294-3538. Voice phone (303) 844-2024. FAX (303) 844-2025. TDD (303) 844-3439.

For complaints involving covered entities located in American Samoa, Arizona, California, Guam, Hawaii, or Nevada:

Region IX, Office for Civil Rights, Department of Health and Human Services, 50 United Nations Plaza-- Room 322, San Francisco, CA 94102. Voice phone (415) 347-8310. FAX (415) 437-8329. TDD (415) 437-8311.

For complaints involving covered entities located in Alaska, Idaho, Oregon, or Washington:

Region X, Office for Civil Rights, Department of Health and Human Services, 2201 Sixth Avenue --Suite 900, Seattle, WA 98121-1831. Voice phone (206) 615-2287. FAX (206) 615-2297. TDD (206) 615-2296.

For all complaints filed by email, send to: OCRComplaint@hhs.gov.

FOR FURTHER INFORMATION CONTACT: Lester Coffey, Office for Civil Rights, Department of Health and Human Services, Mail Stop Room 506F, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201. Telephone number: (202) 205-8725.



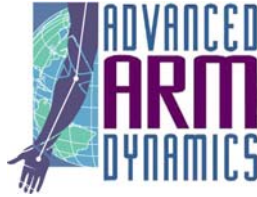
Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Advanced Arm Dynamics.

Signature of Patient or Authorized Representative

Date

If Representative, print name and relationship:



Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

PHI for any purpose other than treatment, billing, and health care operations. This would include the use of a photograph or video to the use of PHI for research purposes.

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Name of person/organization

Name of person/organization

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name of person/organization

Name of person/organization

Expiration Date of Authorization

This authorization is effective unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Advanced Arm Dynamics. You should contact 800-323-6422 to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Patient Signature

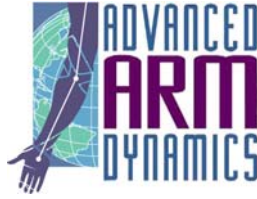
Date

Patient Name (please print)

Signature of Patient Representative

Date

Patient Representative Name & Relationship (please print)



Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Advanced Arm Dynamics or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Advanced Arm Dynamics may or may not agree to restrict the use or disclosure of your protected health information.

If Advanced Arm Dynamics agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Advanced Arm Dynamics reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Advanced Arm Dynamics to use and disclose my health information in accordance with it.

Patient Signature

Date

Patient Name (please print)

Signature of Patient Representative

Date

Patient Representative Name & Relationship (please print)