



### Notice of Privacy Practices \*Summary and Authorization

We use and disclose health information about you for treatment, payment, and healthcare operations.

**Treatment:** We may use or disclose your health information to physicians or other healthcare provider providing treatment for you.

**Payment:** We may use and disclose your health information to obtain payment for services we provided for you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** Unless you give us written authorization, we cannot use or disclose you health information for any reason except those described in this Notice. \*\*\* SEE PROTECTED HEALTH INFORMATION RELEASE SECTION TO GIVE AUTHORIZATION\*\*\*

*I have been made aware of the Privacy Practices and have been given the opportunity to review it in its entirety.*

Acknowledgement of the Privacy Practices

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

\*You may request the complete version of this Notice at any time. This is a summary of the Privacy Act along with Authorization to release medical information to friends or family members

**Please only sign if you would like to give permission for a spouse, sibling, friend or parent to be able to call -in and speak to the Medical Assistant or Doctor regarding your treatment**  
**\*\*\*Protected Health Information Release Authorization\*\*\***

This will authorize **RiversEdge Orthopedics** to use or disclose my protected health information

to (list name): \_\_\_\_\_ as described below for the following purpose:

\_\_\_\_\_ Ask any question over the phone or in office regarding treatment. \_\_\_\_\_ Other (please describe) \_\_\_\_\_  
\_\_\_\_\_

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

### Rx Prescription Refill Policy Rx

Please read carefully the Prescription Refill Policy for our office.

- On-Call Orthopedic surgeons in Kootenai County have agreed to never prescribe controlled medications after clinic hours or on weekends and holidays.
- The patient is responsible for knowing when medication(s) will need to be refilled. (**No early refills!** Patients must follow the prescribing directions, DO NOT overuse/abuse/misuse. If a prescription is lost, stolen, misplaced, etc. no early refills will be given.)
- If you have a refill request, please contact your pharmacy and ask them to fax us the refill request.  
**★★ALL REFILL REQUESTS REQUIRE A TWO-DAY ADVANCED NOTICE FOR PROCESSING★★**
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 6 months.
- Controlled substances/narcotic prescriptions require a follow up appointment every 30 days.
- Post Surgical patients will receive narcotic pain medications for no longer than 30 days. Thereafter, they will need to contact their primary care physician.
- New symptoms and/or events require a clinic appointment. Provider is unable to diagnose via phone.
- Patient must pick up his/her prescription(s) in person, unless pre-authorized by staff.

**\*\*Discourteous behavior toward the office staff will result in discontinuation of further narcotic prescriptions\*\***

I understand & accept the protocol listed above. Failure to comply may subject immediate termination of prescription medications.

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

Please Print: \_\_\_\_\_ D/O/B: \_\_\_\_\_

\*Name of person picking up Rx (if not the same): \_\_\_\_\_