THE STEADMAN CLINIC

Armando F. Vidal, MD

Thank you for your interest in receiving treatment with Dr. Armando Vidal. Please know that we value each potential patient and want to give the best possible treatment to ensure the best possible outcome. Below is information for how to request an image review with Dr. Armando Vidal. Upon receiving this packet, as well as your images, our team will review your information and case to further assess if we are the appropriate provider for your case. Please keep in mind that this may involve Dr. Vidal referring you to another partner in our practice, or another provider. If we deny your image review request, we will not charge your credit card and we will not be able to return your images to you.

We cannot schedule surgery until your images have been reviewed and it has been determined that you are an appropriate candidate for the surgical procedures performed by Dr. Armando Vidal.

HOW TO REQUEST A REVIEW

1. The review process begins by you completing and returning the information contained in the attachments: Clinic Case Review -Patient Consent, Patient History, The Acknowledgement of Notice of Privacy Policy, Credit Card Authorization. In addition, you are required to send your most recent (within 6-months) x-rays and any imaging reports, physician clinic or treatment notes, op notes with photos, injection reports and physical therapy notes for Dr. Vidal's review. You will delay the review of your file if we do not receive the requires items. **Please send copies of your imaging studies and not original films as they will not be returned.**
2. Once Dr. Vidal has reviewed your file, a member of Dr. Vidal's clinical team will contact you with Dr. Vidal's impressions and the most advanced treatment options available. **Please allow three-four weeks for image review processing and follow-up once the images and paperwork are received at our clinic. Our team will reach out to you.**

COST

Due to the complexity of care and time required to review each individual request, a fee of $500 will be required for each joint that we review. If your request involves bilateral of the same joint, the cost will increase $100.00. If your request involves a separate joint, the cost will increase by $500.00 Payment is due at the time of the request and all major credit cards are accepted (Visa,MasterCard, American Express and Discover). We do not accept insurance for our image and record review services.If you miss the agreed upon image review time, we will charge your credit card $50 cancellation fee

PATIENT CHART

In the meantime, please call The Steadman Clinic Scheduling Line at (970) 476-1100 to build a patient chart. This is so that when we do receive your imaging, we can then attach the images to your chart.

CONTACT US

Please send your images and records to our office:

Charlotte Peoples
The Steadman Clinic
181 W Meadow Drive, Suite 400
Vail, CO 81657

Thank you and we look forward to the opportunity to deliver the highest standard of orthopedic care and personal attention to you. Please contact us by phone at 970-401-8946 should you have any questions regarding this process.

THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION

Today's Date _____

Patient Name _____
Last First (Legal) MI Nickname

Date of Birth _____ SSN _____

Cell Phone _____ Work Phone _____ Home Phone _____

Mailing Address _____ City _____

State _____ Zip Code _____

Email address _____

Guarantor Name & DOB (if under 18) _____

Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

Would you like to share your visit notes with your PCP/Referring Provider? Y ☐ N ☐
(If no, skip below)
Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How did you hear about us?

Family/Friend ☐ Website/Social Media ☐ TV/Print Ad ☐ Past Patient ☐ Other ☐

Medical professional referral ☐ Name: _____

Is this a work-related injury? Y ☐ N ☐

PRIMARY INSURANCE _____ MEMBER ID _____ GROUP ID _____

POLICY HOLDER NAME _____ DOB _____ RELATIONSHIP _____

SECONDARY INSURANCE _____ MEMBER ID _____ GROUP ID _____

POLICY HOLDER NAME _____ DOB _____ RELATIONSHIP _____

THE STEADMAN CLINIC

Patient History Form

Please PRINT and fill out completely

Patient Name_____ Todays Date _____

Date of Birth:_____Age:_____Height:_____Weight:_____

History of Injury

Is this related to a: ☐ Work Injury? ☐ Sport Accident? Or ☐ Motor Vehicle Accident? If So, What State? _____

Which Body Part is Injured? _____ ☐Right / ☐Left Hand Dominance: ☐Right / ☐Left

Please list the Injury/Accident Date:_____ If Chronic list how long: _____

Please describe in your own words: (How the Initial Injury Occurred AND how it Limits Your Activity)

_____

_____

Please Rate Your Pain on a Scale of 1 to 10: (10 being the most painful)

Rest: 0 1 2 3 4 5 6 7 8 9 10 At Its Worst: 0 1 2 3 4 5 6 7 8 9 10

Is the Pain: ☐ Constant or ☐ Occasional Has it Been: ☐Worsening ☐ Stable ☐ Improving

Describe the Pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Sensitive to Touch

Do you have Pain at Night? ☐Yes / ☐ No Does the Pain Keep or Wake you from Sleep? ☐ Yes / ☐No

What Symptoms are You Experiencing?

☐Locking ☐Catching ☐Giving Way/Instability ☐ Popping ☐ Grinding ☐ Bruising ☐Numbness ☐Tingling

☐Pain ☐Weakness ☐ Swelling Other (please describe) _____

What, If Anything, Makes Your Symptoms Better?

☐ Rest ☐Activity ☐Cold Therapy ☐ Heat Therapy ☐ Medication ☐ Other (Please describe): _____

What, If Anything, Makes Your Symptoms Worse?

Inactivity ☐ Exercise ☐(describe): _____ Other (Please describe): _____

What Treatment Have You Tried for this Injury?

☐ Nothing ☐Exercise ☐Ice ☐Decreased Activity ☐Bracing

☐ Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started):

☐ Physical Therapy (Date Started): _____ ☐ Acupuncture(Date Started):_____ ☐Other:_____

☐ Medications:_____ ☐ Chiropractic(Date Started): _____

Have You Seen Another Physician for This Injury? Yes ☐ No ☐ Were You Referred? ☐ Yes ☐No

If Yes, Who/Where? _____

Are you Interested in Surgery for this Problem? ☐Yes / ☐ No / ☐ Unsure

Have You Had Any of the Following Tests/Studies?

Test	Date (Month/Year)	Facility? (Clinic/Hospital)
X-Ray		
MRI		
CT Scan		
EMG/NCV		
Discogram		
EKG		
Blood Tests		
Other		

Recreational Activities: _____

Current, regular exercise program (if any): _____

THE STEADMAN CLINIC

Name: _____

Date of Birth: _____

In the spaces below, please tell us a bit about what is going on and some of your symptoms, where you feel pain and how much pain etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTICE OF PRIVACY PRACTICES

181 West Meadow Drive, Suite 400
Vail, Colorado 81657

THIS PRIVACY POLICY AND HIPAA NOTICE OF PRIVACY PRACTICES ("PRIVACY POLICY") DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY. THE EFFECTIVE DATE OF THIS PRIVACY POLICY IS SEPTEMBER 23, 2013.

Purpose

The Steadman Clinic is committed to protecting the privacy of your personal information, laboratory test results, and other protected health information. This Privacy Policy applies to all users of The Steadman Clinic's website ("Website"), as well as employees, management and contractors of The Steadman Clinic.

Our Privacy Obligations

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of patients' health information ("Protected Health Information") and to provide our patients with this Privacy Policy, outlining our legal duties and privacy practices with respect to their Protected Health Information. Users of the Website and patients are referred to as "you" or "your" throughout this Privacy Policy. The Steadman Clinic and its workforce are referred to as "we".

Responsibilities of The Steadman Clinic

The Steadman Clinic has established this Privacy Policy, including implementing and maintaining the various policies and procedures described herein, as an overall program in accordance with HIPAA guidelines.

Use and Disclosure Of Health Information

The Steadman Clinic is permitted by federal privacy law to use and disclose our Protected Health Information for treatment, payment, healthcare operations, and other purposes permitted or required by law. Protected Health Information is the information we create and obtain in providing our services to you, including billing documents related to the services we provide to you.

We may use and disclose your Protected Health Information for the following purposes:

1. Treatment. We may use or disclose your Protected Health Information for treatment purposes. For example, we may use your Protected Health Information to perform our testing services and disclose your Protected Health Information, including laboratory test results, to physicians and other health care providers involved in your care.

2. Payment. We may use or disclose your Protected Health Information to obtain payment for health care services we provide. For example, we may disclose your information to your health plan to receive payment for the services provided to you.

3. Health Care Operations. We may use and disclose your Protected Health Information for our health care operations. These activities include, for example, monitoring the quality of our testing services, reviewing the competence or qualifications of laboratory professionals, conducting training programs, performing accreditation, certification, licensing and credentialing activities, and other business and administrative functions.

4. Personal Representatives; Minors; Persons Involved in Your Care or Payment for Your Care. We may disclose Protected Health Information about you to your authorized personal representative, as defined by applicable law, or to an administrator, executor, or other authorized person responsible for your estate. As permitted by federal and state law, we may disclose Protected Health Information about minors to their

parents or guardians. We may disclose your Protected Health Information to a person involved in your care or payment for your care, such as a family member or close friend, as designated by you or as we identify using our best efforts. We may use or disclose your Protected Health Information for disaster relief efforts or to notify a family member or close friend of your location or general condition. If you do not want us to use or disclose your Protected Health Information in these ways, you must notify us using the contact information at the end of this Privacy Policy.

5. Communications About Our Products and Services. We may use and disclose your Protected Health Information to contact you about our products and services which we believe may be of interest to you.

6. As Required by Law. We must disclose your Protected Health Information when required to do so by any applicable federal, state or local law. For example, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases.

7. Health Oversight Activities. We may disclose your Protected Health Information to a health care oversight agency for activities that are authorized by law, such as audits, investigations, inspections, and licensure activities. For example, we may disclose your Protected Health Information to agencies responsible for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

8. Research. Under certain conditions, such as following review by an institutional review board, we may use or disclose Protected Health Information for research purposes. We may allow researchers to look at Protected Health Information to develop a study, identify prospective research participants, or for similar purposes provided that the information is not removed from our premises.

9. Disclosures to Business Associates. We may disclose your Protected Health Information to other companies or individuals, known as "business associates," who need your information to provide services to us. For example, we may use another company to perform billing services on our behalf. We will disclose your Protected Health Information only after a business associate has agreed in writing to safeguard that information. Our business associates also are required by law to protect the privacy of your Protected Health Information.

10. Judicial and Administrative Proceedings. Under certain circumstances, we may disclose your Protected Health Information in the course of a judicial or administrative proceeding in response to a court order, subpoena, or other lawful process.

11. Fundraising. We may use certain information to contact you about fundraising efforts, either on our behalf, or on behalf of the Steadman Philippon Research Institute. If you receive such a fundraising communication, you will be provided an opportunity to opt-out of receiving such communications in the future.

12. Law Enforcement; Threats to Health or Safety. We may disclose your Protected Health Information to the police or other law enforcement officials as required by law or in compliance with a court order, warrant, subpoena, summons, or similar process authorized by law. Under certain circumstances, we also may disclose Protected Health Information to law enforcement officials when the information is needed to: identify or locate a missing person or a suspect, fugitive, or material witness; determine whether an individual has been a victim of a crime; determine if a death resulted from criminal conduct; or investigate suspected criminal activity on our premises. We may also disclose Protected Health Information if necessary to prevent or reduce the risk of a serious and imminent threat to the health or safety of an individual or the general public.

13. Workers Compensation. If you seek compensation for a work-related illness or injury, we may disclose your Protected Health Information as necessary to comply with requirements of workers' compensation or similar programs that provide benefits for work-related injuries or illness without regard to fault.

14. All Other Uses and Disclosures of Protected Health Information. We will ask for your written authorization before using or disclosing your Protected Health Information for any purpose not described above. Specific examples of such types of uses include (1) most uses of your health information for marketing purposes and (ii) disclosures of your health information that constitute the sale of your health information. You may revoke your authorization, in writing, at any time, except that a revocation will not affect any use or disclosures we have made in reliance on your authorization.

15. Disaster Relief: We may use and disclose your health information to assist disaster relief efforts

16. Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product or product defects, or postmarketing surveillance information to enable product recalls, repairs or replacement.

17. Coroners, Medical Examiners and Funeral Directors: We may disclose health information consistent with applicable law concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

18. Organ and Tissue Donation: We may disclose health information consistent with applicable law to organizations that handle organ, eye or tissue donation or transplantation.

19. Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose medical information to authorized federal officials for intelligence and national security purposes.

20. Correctional Institutions: If you are an inmate, we may disclose information necessary for your health and the health and safety of other individuals in the institution or its agents.

Your Rights

The health and billing records we maintain are the physical property of The Steadman Clinic. The information in those records, however, belongs to you. You have the following rights with respect to your Protected Health Information. To exercise any of these rights, please contact us.

- Access to Protected Health Information. You or your authorized or designated personal representative have the right to inspect and copy your Protected Health Information and billing information maintained by us. We may deny access to certain information for specific reasons, for example, where state law prohibits such patient access. Health information that is maintained electronically may be accessed in an electronic format. We may assess a reasonable, cost-based fee for production of records.
- Restrictions on Uses and Disclosures. You have the right to request restrictions on our use and disclosure of your Protected Health Information. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If we do agree to a requested restriction, we will notify you in writing. If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan.

- Confidential Communications. You have the right to request that we communicate with you about your Protected Health Information by alternative means or to an alternative address. Your request must be in writing and must specify the alternative means or location.

- Correct or Update Information. If you believe the Protected Health Information or billing information we maintain about you contains an error, you may request that we correct or update your information. Your request must be in writing and must explain why the information should be corrected or updated. We may deny your request under certain circumstances, if the information (i) was not created by us; (ii) is not part of the health information kept or for The Steadman Clinic; (iii) is not part of the information that you would be permitted to inspect or copy; or (iv) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

- Accounting of Disclosures. You may request in writing a list, or accounting, of certain disclosures of your Protected Health Information made by us or our business associates for purposes other than treatment, payment, healthcare operations, and certain other activities. The first list will be provided to you for free, but you may be charged for any additional lists requested during the same year.

Our Responsibilities

The Steadman Clinic is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Notify you following a breach of your health information that is not secured in accordance with certain security standards.

We reserve the right to change the terms of this notice and to make the provisions of the new notice effective for all health information that we maintain. If we change the terms of this notice, the revised notice will be made available upon request, posted to our website and posted in prominent locations at The Steadman Clinic, and will be effective for all Protected Health Information we maintain, including information created or received prior to implementation of the new notice.

Health Care Providers Covered By This Notice

This notice applies to The Steadman Clinic and its personnel, volunteers, students and trainees. This notice also applies to other health care providers that come to The Steadman Clinic to care for patients, such as physicians, physician assistants, therapists and other health care providers who are not employed by The Steadman Clinic. These health care providers will follow this notice for information they receive about you from The Steadman Clinic, but these providers may follow different practices at their own offices of facilities.

Questions And Complaints

If you want more information about our privacy practices pertaining to Protected Health Information, have general questions or concerns, or want to report a problem regarding the handling of your information, please contact us at (970) 476-1100.
You also may write to us at:

The Steadman Clinic, Professional LLC
Attn: Operations Manager
181 West Meadow Drive, Suite 400
Vail, Colorado 81657
Fax: 970.479.5835

Or

The Steadman Clinic, Professional LLC
Attn: CEO
181 West Meadow Drive, Suite 400
Vail, Colorado 81657
Fax: 970.479.5835

If you believe your privacy rights have been violated, you may file a complaint at The Steadman Clinic by delivering the written complaint to the address above. You may also file a complaint by contacting the Secretary of the U.S. Department of Health and Human Services (HHS) at:

Office for Civil Rights
U.S. Department of Health and Human Services 200
Independence Ave. S.W. Room 509F HHH Bldg.
Washington, DC 20201
OCRComplaint@hhs.gov

We cannot, and will not, retaliate against you for filling a complaint. We cannot, and will not, require you to waive the right to file a complaint with HHS as a condition of receiving treatment from the hospital.

Website: Notice is published on website at: www.thesteadmanclinic.com

Privacy notice updated August, 2013.

Armando F Vidal
Orthopaedic Surgeon specializing in Knee, Shoulder, and Sports Surgery
Main: 970-476-1100| Office: 970-401-8946| Fax: 970-672-0846

CLINICAL CASE AND X-RAY AND/OR MRI REVIEW
PATIENT CONSENT FORM

This form is to consent for Review

PATIENT INFORMATION:

Full Name: _____

Date of Birth: _____

Address: _____

_____

Phone Number(s): _____

Email address: _____

Please initial: _____ I am 18 years or older _____ I am under the care of a physician

Because there is not an opportunity for a physical examination, this Clinical Case and X-ray/MRI review differs from diagnostic services typically provided by a physician. Without the benefit of examining you in person and observing your physical condition, Dr. Vidal may not be aware of facts or information that could influence or be critical to his opinion therefore this review is preliminary and limited. By requesting this service and signing below, you are acknowledging that you are aware of this limitation, agree to assume the risk of this limitation and agree this review is not intended to replace a full medical evaluation or an in-person visit with a physician.

Further, I acknowledge that I have received the Notice of Privacy Practices of The Steadman Clinic and understand the explanation of how they may use and disclose confidential health information that identifies me. This executed consent is to allow The Steadman Clinic use and disclosure of health information about my Clinical Case and X-Ray/MRI Review. I can revoke my consent in writing at any time except to the extent that The Steadman Clinic has already relied on my consent.

_____ _____ _____
Signature of patient or patient representative Print name of patient representative if applicable Date

THE STEADMAN CLINIC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

Name of Patient *(please print)* ---------- Date of Birth ----------

I hereby acknowledge that I received the Steadman Clinic´s Notice of Privacy Practices.

Signature of patient or patient representative ---------- Date ----------

Documentation of Good Faith Efforts
To obtain patient´s acknowledgement that they received provider´s Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office/hospital on ---------- and was provided with a copy of Covered Entity´s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because: ----------
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- ☐ Other reason (describe below): ----------

Signature of Employee Completing Form ---------- Date ----------

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider´s Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specify how those "Good Faith Efforts" should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.

CREDIT CARD PAYMENT AUTHORIZATION FORM

As part of the Imaging Review Process for Dr. Armando Vidal; a non-refundable fee in the amount of $500.00 will be required. For your convenience, The Steadman Clinic accepts all major credit cards.

Please sign and complete this form in its entirety to authorize The Steadman Clinic to make a one-time debit for these services to your credit card listed below. This is permission for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account.

By signing this form you also authorize a cancellation fee of $50.00 if you miss the agreed upon appointment time.

I, _____ authorize The Steadman Clinic to charge my credit card in the amount of $500 for imaging review services provided by Dr. Armando Vidal

Check Card Type: ____ Visa ____ MasterCard ____American Express ____Discover

Cardholder Name: _____

Credit Card Number: _____ Expiration ____/____ CVV _____

Billing Address: _____

City, State, Zip: _____

Date of Birth:_____

Email Address:_____

Phone number: _____

By signing below, I authorize The Steadman Clinic to charge the credit card indicated on this authorization form according to the terms and services outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to terms indicated in this form.

Signature _____ Date _____