



Please plan to **arrive at least 15 minutes** prior to your scheduled appointment and allow approximately one to two hours for your office visit. Enclosed you will find directions and New Patient paperwork.

Please bring the following items with you the day of your appointment:

- Completed Patient Health Summary.
- All current Insurance Cards and photo ID for scanning/copying at every visit.
- If your insurance plan requires a referral from your primary care physician, you will be required to secure the referral and/or authorization prior to the office visit. Please bring the referral and/or authorization with you or check your primary physician's office prior to your visit to confirm that your visit has been approved and the authorizations have been sent to us.
- ** Please bring actual MRI films or disc/ X-rays/CT Scans with the radiology reports in addition to any other testing that pertains to the reason for your visit. Your appointment may need to be rescheduled if you are unable to bring prior testing films/results.

To expedite the registration process we are providing you a copy of our Crystal Clinic Orthopaedic Center forms so that you will be able to read and review them **PRIOR** to your office visit. We will be asking you to electronically sign each of these forms at the time of check in, for every visit.

Thank you again for choosing the Crystal Clinic Orthopaedic Center as your orthopaedic healthcare provider.



Many managed care health plans require that you have a referral from your Primary Care Physician to be seen by a **specialist**. We are under contract with these plans to see patients provided that we have received a written authorization from the Primary Care Physician or health plan. To obtain a written referral, the process originates with the Primary Care Physician. Generally, the referrals will cover either a specified number of visits, or a specified period of time, such as 30-60-90 days. Therefore, if your health plan requires that you have a written referral to see a specialist it is the patient's responsibility to coordinate this through your Primary Care Physician or health plan.

It is the policy of the Crystal Clinic, Inc. and Crystal Clinic Orthopaedic Center to have a referral in place before the date of service. We suggest that you check with your Primary Care Physician 3-5 days before your office visit to make sure that they have the referral in place. Failure to obtain a referral prior to your visit will require you to reschedule your appointment. Please follow-up before you arrive at our office. For verification, please use the attached space to record any information you may receive upon requesting your referral.

Primary Care Physician:_____	Telephone Number:_____
Contact Person:_____	Date Called In:_____
Notes:_____	

Please note that it is the patient's responsibility to be familiar with their insurance policy. If you have questions regarding your insurance coverage, a contact number should be listed on your insurance card.

If you are being seen on an emergency basis, a referral must be obtained within 24hours of your visit. Please bring the written referral with you, or have your Primary Care Physician or health plan fax your referral to (330) 670-4054.

I have read the above policy and understand that I am financially responsible for services rendered without written authorization when required by health plan.

Signature:_____ Date:_____

Date of Service for referral is required:_____

For Office Use Only: Account No: _____

For Office Use Only:

Place of Service	EST	NEW	PVT	ICO
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**CRYSTAL CLINIC
ORTHOPAEDIC CENTER**

A partnership with Summa Health System

Dominance:	R	L	B
Injured Side:	R	L	B
Injury Date:	_____		
Occupation:	_____		
# Years at This Job:	_____		
Date Last Worked:	_____		
Referring Phys:	_____		

PATIENT NAME & ADDRESS	HOME PHONE	DATE OF BIRTH	AGE	ACCOUNT NO.
	WORK PHONE			HMS #

Employer: _____ Doctor: _____

Patient Health Summary

Please read all instructions and complete the following.

Medical Problems or Conditions: *Please check yes or no for the following medical conditions that you are currently being treated for or have been in the past. Please add any conditions not listed.*

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	GERDS	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			Skin Infections	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>	Cellulitis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker / Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	-non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	Osteomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Transmittable disease	<input type="checkbox"/>	<input type="checkbox"/>	Pagets disease	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Smoker / Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	ASHD	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____					

List all past Surgeries: *Include month, year, and name of physician*

<input type="checkbox"/> None	_____
_____	_____
_____	_____
_____	_____

List all current Medications: *Include Prescribed, Over-the-Counter, Herbal, and Vitamins with dosage and frequency.*

<input type="checkbox"/> None	_____
_____	_____
_____	_____
_____	_____

List all Allergies: *Include Medication, Seasonal, Latex, Tape, Iodine, or Metals and the reaction to each.*

<input type="checkbox"/> No Known Drug Allergies	Latex <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____
_____	_____
_____	_____

Continue other side →

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

- I. **CONSENT FOR MEDICAL PROCEDURES AND TREATMENT:** Permission is hereby granted to the Crystal Clinic Orthopaedic Center, LLC (CCOC), Crystal Clinic Inc. (CCI), Professional Anesthesia Service, Inc. (PASI), Anesthesia & Pain Center of Akron (APCA) and all affiliated entities for such medical procedures, including the taking of photographs for treatment purposes only, as may be deemed necessary by my physician and/or his or her designee. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to be as to the results of treatments, examinations, emergency services, or hospital care.
- II. **CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING:** I hereby give my consent to have testing for blood-borne infectious disease, including, but not limited to Hepatitis, acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and/or Hepatitis if a physician orders such test(s) or if ordered by protocol. The potential side effects of this testing are those encountered during the routine procedure of obtaining blood specimens. The minor complications may include discomfort from the needle stick and light burning, bleeding or soreness at the site where blood was obtained. The results of this test will become a part of my confidential medical record. I understand that refusal to consent will not result in denial of admission and/or treatment by the Crystal Clinic Orthopaedic Center or any of its affiliates. Notwithstanding the foregoing, I agree that if any healthcare worker is exposed to my blood or other bodily fluid, CCOC may perform tests on my blood or other bodily fluid to determine the presence of any communicable disease. Any test result obtained as part of this process does not become part of my medical record.
- III. **TEACHING PROGRAMS:** I understand the CCOC is a facility that promotes teaching and education opportunities and, therefore, I may be seen and examined by supervised participants as part of the educational program.
- IV. **ACKNOWLEDGMENT OF ADVANCE DIRECTIVE / LIVING WILL AND PATIENT HANDBOOK:** I have been offered Advanced Directive and Living Will information and have been informed that additional information will be given to me at any time at my request during my hospitalization, outpatient, or other visit. Patient Rights and Responsibilities and other information relating to my stay are available to me in Patient Registration.
- Do you have an Advance Directive / Living Will? Yes No Durable Power of Attorney? Yes No
- I acknowledge that my Advance Directive / Living Will, according to CCOC and CCI policy, will not be implemented during any visit to a satellite facility (e.g., ambulatory surgery center, hospital based physician clinic) for outpatient services, while in surgery, or during the immediate post-operative period.
- V. **CONSENT TO DISCLOSE PATIENT INFORMATION AND OPT OUT OF THE FACILITY DIRECTORY:** The CCOC, CCI or its affiliates should not divulge any identifying information about patients without their consent. With this in mind, your permission is required to release information about your presence at the CCOC or one of its affiliates during your stay. By choosing to opt out of the Facility directory, your location in the hospital will not be released. In addition, you will not receive flowers, cards, phone calls or clergy visits.
- VI. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have been given the CCOC, CCI and its' affiliates Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the CCOC's HIPAA Privacy Officer.
- No Yes – Date Issued: _____
- VII. **PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT:** I acknowledge that I have received a copy of the Patient Rights and Responsibilities and have had an opportunity to ask questions.
- VIII. **RELEASE OF INFORMATION:** I authorize CCOC, CCI and its affiliates and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this admission or outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work-related, I authorize the aforementioned entities to release any information from my medical record to my employer and/or its designee. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood borne diseases.

I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses and technicians at the CCOC, home health agencies, ambulance companies, and such other health care agencies involved in my care during and after transfer or discharge from the hospital. I further acknowledge that my medical records will be utilized in the CCOC's (and the CCOC's affiliates) utilization review, performance improvement, peer review and other similar processes and studies. I also acknowledge that my medical records will also be made available to government agencies as required by law. Information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the hospital and its affiliates may be stored electronically and made available through computer networks to CCOC personnel, as well as physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility in the area affiliated with the CCOC, my medical records may be made electronically available to the other facility, as well as physicians

involved in my care and their offices. This will assist my physician and to other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities that are not affiliated with the CCOC and its affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I understand that in accordance with the Safe Medical Device Act of 1990, the CCOC and its affiliates may be required to release certain information obtained in the course of my diagnosis and treatment to a manufacturer of medical devices and the Food and Drug Administration (FDA). I understand that federal law may require the CCOC to disclose the following information including but not limited to: my name, address and social security number. In accordance with federal law, I hereby authorize the release of this information.

IX. ASSIGNMENT OF BENEFITS: I hereby assign to CCOC, CCI, their affiliates and CCOC's hospital-based physicians the right to be paid directly by my health insurance carrier or other health benefit plan for the services provided to me, my minor child, or other person entitled to health care benefits for the services provided in return for the services rendered and to be rendered by CCOC, CCI and/or facility-based physicians. I hereby authorize payment of these benefits otherwise payable to be my designated insurance company(ies), except as otherwise provided by law. This assignment and transfer shall be for the purpose of granting CCOC, CCI, its' affiliates and/or hospital-based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of CCOC, CCI, its' affiliates and/or hospital-based physicians to pursue any such right of recovery.

X. FINANCIAL AGREEMENT: In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated.

I understand that I am financially responsible to the CCOC for charges not covered by my insurance company(ies), except as otherwise provided by Law. In the event that CCOC and/or its affiliates has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by CCOC and/or its affiliates.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from CCOC, CCI and its affiliates. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

NOTICE: All physicians, including anesthesia, radiology and pathology physicians that render professional services at the Crystal Clinic Orthopaedic Center are independent practitioners and are not employees or agents of the hospital. They are independent contractors acting as your (the patient's) agent. CCOC is not responsible for the acts or omissions of the physicians that are not directed or controlled by CCOC.

XI. MEDICARE PATIENT CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare / Medicaid claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

XII. OWNERSHIP INTEREST: I have been informed and understand that my physician may have an ownership, directly or indirectly, in CCOC. I have a right to review the list of owners of CCOC.

XIII. PERSONAL VALUABLES: I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital and its affiliates shall not be liable for the loss or damage to any money, jewelry, documents, or other articles of unusual value and small size, unless placed therein. CCOC, CCI and/or any of its' affiliates shall not be liable for loss or damage to any other personal property the patient chooses to keep in their room including dentures, glasses, hearing aids, prostheses, etc. I understand and agree that if the Hospital at any time believes there may be a weapon, explosive devices, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may confiscate any of the above items that are found and dispose of them as appropriate, including delivery of any items to law enforcement authorities.

XIV. TOBACCO USE POLICY: The Crystal Clinic Orthopaedic Center is a tobacco free facility. I understand that while I am a patient at the CCOC I may not use tobacco products.

I hereby certify and state that I have read, and that I fully and completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

<ESIG:DESC=Patient or Other>

Signature of Patient / Parent / Guardian / Conservator

Date

If Other than Patient, Indicate Relationship

On File

Signature of Witness

Registrar Initials

Date

CRYSTAL CLINIC ORTHOPAEDIC CENTER

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.

The terms of this Notice of Privacy Practices apply to Crystal Clinic Orthopaedic Center, Crystal Clinic Inc., any entities or facilities owned by or affiliated with Crystal Clinic Orthopaedic Center and the Medical Staff and their dependent practitioners (collectively referred to as "Crystal Clinic Orthopaedic Center"). These entities and people operate together as a clinically integrated health care arrangement. This clinically integrated health care arrangement includes our main facility and remote offices, and all of our programs, services, departments and units within our health care facilities. Crystal Clinic Orthopaedic Center is made up of many people such as our doctors, physician assistants, nurses, therapists, specialists, other health care professionals permitted by us to provide services to you, and staff, students, residents, trainees, volunteers and others involved in providing your care and services. These entities and people will share personal, protected health information of patients as necessary to carry out treatment, payments and health care operations as permitted by law.

Crystal Clinic Orthopaedic Center is required by law to maintain the privacy of our patients' personal, protected health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal, protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal, protected health information maintained by us. You may receive a copy of any revised Notice at any Crystal Clinic Orthopaedic Center point of registration or a copy may be obtained by mailing a request to the Privacy Officer of Crystal Clinic Orthopaedic Center at 3925 Embassy Parkway, Suite 250, Akron, OH 44333.

USES AND DISCLOSURES OF YOUR PERSONAL, PROTECTED HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal, protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal, protected health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal, protected health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if, after you leave the surgery center, you are going to receive home health care, we may release your personal, protected health information to that home health care agency so that a plan of care can be prepared for you. We may also participate in electronic health information exchanges that facilitate access to personal, protected health information by other health care providers who provide you care. For example, if you receive care from another provider that participates in the health information exchange, this exchange will allow us to make your personal, protected health information available to the provider as needed for your treatment.

Uses and Disclosures for Payment. We will make uses and disclosures of your personal, protected health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal, protected health information as necessary and as permitted by law, for our health care operations that include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal, protected health information for purposes of improving the clinical treatment and care of our patients. We may disclose protected health information to doctors, nurses, technicians, medical students, volunteers and other persons for review and learning purposes and for the operation of educational programs. We may also disclose your personal, protected health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Our Patient Directory. Crystal Clinic Orthopaedic Center maintains a patient directory listing the name, room number, general condition and, if you wish, your religious affiliation. Unless you choose to have your personal, protected health information excluded from this directory, the information, excluding your religious affiliation, will be disclosed to anyone who requests it by asking for you by name. This information, including your religious affiliation, may be also provided to members of the clergy. You have the right during registration to have your information excluded from this directory.

Family and Friends Involved in Your Care. With your approval, we may disclose your personal, protected health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal, protected health information with such individuals without your approval. We may also disclose limited personal, protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide some of your personal, protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information. Fundraising. We may contact you to donate to a fundraising effort for or on our behalf. You have the right to "opt-out" of receiving fundraising materials or communications and may do so by sending your name and address to the Privacy Officer of Crystal Clinic Orthopaedic Center at 3925 Embassy Parkway, Suite 250, Akron, OH 44333 together with a statement that you do not wish to receive fundraising materials or communications from us.

Appointments and Services. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your

personal, protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders not to be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy Officer of Crystal Clinic Orthopaedic Center at 3925 Embassy Parkway, Suite 250, Akron, OH 44333.

Health Products and Services. We may from time to time use your personal, protected health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal, protected health information for research purposes. For example, a researcher may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board that oversees the research, or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal, protected health information without your authorization. We may release your personal, protected health information:

- for any purpose required by law;
- for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- as required by law if we suspect child abuse or neglect; we may also release your personal, protected health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military as required by armed forces services; we may also release your personal, protected health information if necessary for national security or intelligence activities;
- to workers' compensation agencies if necessary for your workers' compensation benefit determination.

RIGHTS THAT YOU HAVE

Access to Your Personal, Protected Health Information. You have the right to receive a copy and/or inspect much of the personal, protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you a reasonable fee if you request a copy of the information. We may also charge for postage if you request a mailed copy. Patients or their legal representatives may request access to their personal, protected health information by completing the Authorization for Release of Information Form. This Form is available from Health Information Management or the Patient Accounts Department.

Amendments to Your Personal, Protected Health Information. You have the right to request in writing that personal, protected health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If we make an amendment or correction that you request, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Amendment request forms may be obtained from Health Information Management.

Accounting for Disclosures of Your Personal, Protected Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal, protected health information after May 2009. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from Health Information Management. The first accounting in any 12-month period is free; you will be charged a reasonable fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Personal, Protected Health Information. You have the right to request restrictions on certain uses and disclosures of your personal, protected health information for treatment, payment, or health care operations by contacting the Privacy Officer. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the Privacy Officer of Crystal Clinic Orthopaedic Center at 3925 Embassy Parkway, Suite 250, Akron, OH 44333. Any agreed-to restriction will not limit patient directory disclosures unless you exclude yourself from the patient directory.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer, Patient Liaison, or the Compliance Hotline. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing within 180 days of a perceived violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

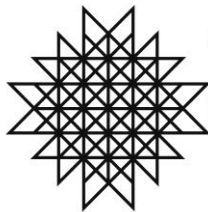
If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer of Crystal Clinic Orthopaedic Center at 3925 Embassy Parkway, Suite 250, Akron, OH 44333, telephone (330) 670-6144. You may also call the Compliance Alert Line of Crystal Clinic Orthopaedic Center at 330-670-4799.

EFFECTIVE DATE

This Notice of Privacy Practices is effective May 2009.

As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.





CRYSTAL CLINIC ORTHOPAEDIC CENTER

A partnership with Summa Health System

May, 2011

Dear Patient:

The Crystal Clinic Orthopaedic Center (CCOC) began providing specialized orthopaedic services as a hospital on May 27, 2009. The Crystal Clinic physicians and the staff of the CCOC are pleased to have you as an established patient and welcome those of you who are new to our services. The services provided in our hospital include those provided in our ambulatory clinics (formerly our physician offices), in our Montrose surgery center, and in our hospital facility located at the St. Thomas campus of Summa Health System. As patients in the ambulatory clinics of the CCOC hospital, we want you to understand the billing requirements and payment policies prior to your treatment.

The services you receive in the CCOC ambulatory clinics will result in you receiving two separate bills for your visit. One bill will come from Crystal Clinic, Inc. which will be for the physician's professional services. The other bill will be from the Crystal Clinic Orthopaedic Center hospital and will include a facility charge, charges for ancillary services, if provided, and charges for any other products or services provided during the visit. This latter bill will be just like one you receive for any other services provided in a hospital outpatient department.

Depending on your specific insurance plan, the services you receive in a CCOC ambulatory clinic may be considered an "Outpatient Benefit" because the Crystal Clinic physicians are now providing their services in a hospital-based setting. Your insurance plan may require you to pay a deductible and/or co-insurance amount instead of an office co-payment amount for the services you received from the CCOC. Please refer to your policy handbook for information specific to you. We will be happy to answer any questions you have regarding how this change will or will not affect your "out-of-pocket" expense. Please contact your insurance carrier directly and ask them to confirm your benefits for services provided in an outpatient hospital setting, or feel free to contact one of our Patient Advocates. As in the past, you may make payment by cash, check, money order or bank card. We accept Visa, MasterCard and Discover.

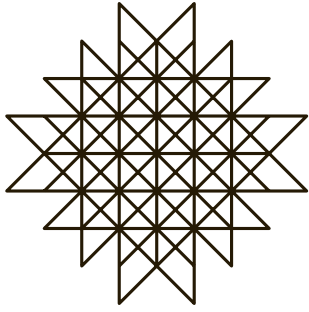
Questions concerning billing for the Crystal Clinic Orthopaedic Center hospital charges should be directed to the attention of Odyssey Health Systems at **(330) 668-7428** or **(800) 818-0886**.

Should you have questions regarding your Crystal Clinic, Inc. bill for physician services, you may call **(330) 668-6740** or **(800) 818-0886**.

If at any time prior to, during, or after your course of orthopaedic care you have questions concerning your treatment or account balance, please do not hesitate to bring them to our attention. We remain pleased and honored to serve you.

Sincerely,

Crystal Clinic Physicians & Crystal Clinic Orthopaedic Center Staff



CRYSTAL CLINIC ORTHOPAEDIC CENTER

A partnership with Summa Health System

IMPORTANT BILLING NOTICE TO OUR PATIENTS

Effective May 27th, 2009, the services you receive in the Crystal Clinic Orthopaedic Center's ambulatory clinics (formerly physicians offices) will result in you receiving two separate bills for your visit.

One bill will be for the physician's professional services (Crystal Clinic Inc.). The other bill will come from the Crystal Clinic Orthopaedic Center hospital (CCOC) and will include facility charges such as, but not limited to, room charges, supplies and technical services.

Please call your insurance company and verify your insurance benefits for an outpatient hospital. Today we will be collecting an amount equivalent to the former office co-pay since we do not know how your insurance company will process the claim under your outpatient hospital benefits. We will be happy to answer any questions regarding how this change may or may not affect your "out of pocket" expense.

Thank you for choosing Crystal Clinic Orthopaedic Center as your orthopaedic healthcare provider. We are truly privileged and honored to serve you.

***I have read and understand the information stated above.**

Patient Name _____ Date of Birth _____

Signature of Patient or Representative _____ Date _____

Relationship to Patient _____



DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice so that you can make an informed decision regarding your care. The CCOC supports initiatives that provide transparency in healthcare. We believe that corporate compliance, ethics, and integrity are essential elements in any healthcare organization. With the rising costs of healthcare, Americans are interested in physician, hospital, insurance company, supplier, and other industry relationships. As such, we have chosen to make certain disclosures to the public on arrangements that may be perceived as conflicts of interest.

According to Federal Regulations, Crystal Clinic Orthopaedic Center meets the definition of a “physician-owned hospital” under 42 CFR 489.3. The hospital is owned, in part, by physicians who may be providing your care. A list of those physicians can be provided for review upon request.

You have the right to choose the provider of your health care services. Although we believe that Crystal Clinic Orthopaedic Center will be able to meet your needs, you have the option to use a facility other than Crystal Clinic Orthopaedic Center. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he or she does not maintain privileges at that facility. If desired, your physician or another staff member can provide information about alternative health care providers.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Crystal Clinic Orthopaedic Center. We welcome you as a patient and value our relationship with you.