Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

AUSTIN SPORTS MEDICINE

900 West 38th Street, Suite 300 • Austin, TX 78705-1130 • 512-450-1300 • Fax 512-450-1339 • www.austinsportsmed.com

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your health coverage carrier. For your convenience, we will accept cash, check and most major credit cards.
- Your insurance is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the co-payment at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance remaining after your health plan pays is your responsibility. Payment is due upon receipt of a statement from our office.
- A surgery deposit will be required prior to your surgery date. We will estimate the surgeon's fees, not covered services, as well as the expected payment from your insurance company to determine the deposit amount. After your insurance company has paid our office and the actual patient responsibility is calculated you will be billed for amounts due or refunded amounts that you have overpaid. PLEASE NOTE THAT THIS ESTIMATE DOES NOT INCLUDE CHARGES FROM THE HOSPITAL, SURGERY CENTER, ANESTHESIA, PATHOLOGY, RADIOLOGY, LAB, ETC. YOU WILL RECEIVE SEPARATE BILLS FROM THESE ENTITIES FOR THEIR SERVICES
- We will look to the **adult accompanying** a minor for all services rendered to minor patients.
- Most surgeries include a 10-90 day period of covered postoperative office visits known as the "Global Period" as established by your health plan. This does not include x-rays, physical therapy, or durable medical equipment that may be prescribed. If you have a balance on your account, you will receive a total of three statements. Should your account become more than 90 days past due, your account will be sent to a collection agency.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms.
I also understand and agree that such terms may be amended from time to time by the practice.

_____

SIGNATURE OF PATIENT or RESPONSIBLE PARTY IF A MINOR PRINTED NAME DATE

WORKER'S COMP DISCLOSURE

If you are seeking care at this facility for an injury/condition that occurred due to work, please note that we are required by the Texas Worker's Compensation law to handle your claim with your employer's workers compensation insurance carrier (pursuant to TWCC Rule 120.1 & 120.0). Please mark the applicable statement:

_____ I certify that my injury/condition IS work related _____ I certify that my injury/condition is NOT work related

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

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PATIENT INFORMATION

**** All sections MUST be completed. If not applicable, please indicate as "N/A" ****

Today's Date _____

Patient Information:

Last Name _____ First Name _____ M.I. _____ Nickname _____ Birth Date _____
Age _____ Sex _____ Marital Status: ☐ S ☐ M ☐ W ☐ D
Social Security No. _____ Driver's License State and # _____
Permanent Address _____ Apt # _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email _____
Preferred Language _____ Race: ☐ Decline ☐ Asian ☐ African American ☐ Caucasian ☐ Native American
Ethnicity: ☐ Decline ☐ Hispanic or Latino ☐ Non Hispanic or Latino
Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker Start Date _____ Stop Date _____
Occupation _____ Employer/School Name _____
Primary Care / Family Physician's Name _____
Pharmacy Name _____ Phone _____ Address or Intersection _____
Have you been treated by one of our physicians? ☐ No ☐ Yes by Dr. _____ Approx Date _____
Was your injury sustained on the job? _____ Has a claim been filed with your employer? _____

Referred By:

☐ Doctor ☐ Hospital/Clinic ☐ Patient ☐ Friend/Co-Worker ☐ Family Member ☐ Employer ☐ TV ☐ Internet ☐ Radio ☐ Other
If referred by a Physician: Last Name _____ First Name _____

Emergency Contact: _____ Relationship to the patient: _____
I authorize Austin Sports Medicine to release treatment/account information to the following people: _____

_____

MEDICAL INSURANCE INFORMATION

**** Complete with **insured's** information ****

Primary Insurance _____
Insured's Name _____
Date of Birth _____
Social Security # _____
Relationship to Patient _____
Claims Address _____
City _____ State _____ Zip _____
ID# _____ Group # _____
Employer _____

Secondary Insurance _____
Insured's Name _____
Date of Birth _____
Social Security # _____
Relationship to Patient _____
Claims Address _____
City _____ State _____ Zip _____
ID# _____ Group # _____
Employer _____

Name: _____

DOB: _____

Chart: _____

Age: _____

Date: _____

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Acknowledgement of Review of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Patient Name: _____ Account Number: _____

Signature: _____ Date: _____

Relationship to Patient (if other than patient): _____

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

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MEDICAL HISTORY

Today's Date _____ Age _____ Height _____ Weight _____

Primary Physician _____

ILLNESSES / REVIEW OF SYSTEMS (Provide details to all yes answers)

Yes	No	Details	Medication
☐	☐	High Blood Pressure	
☐	☐	Heart Problems/Pacemaker/Chest Pain	
☐	☐	Diabetes	
☐	☐	Cancer	
☐	☐	Asthma/Lung Disease/Shortness of Breath	
☐	☐	Hepatitis/Liver Disorders	
☐	☐	Thyroid Problems	
☐	☐	Bleeding Problems/Stroke	
☐	☐	Blood Clots/Phlebitis	
☐	☐	Kidney Disease	
☐	☐	Frequent Bladder Infections	
☐	☐	Stomach Ulcer/Bleeding	
☐	☐	Depression/Mental Illness	
☐	☐	Recent Weight Change	
☐	☐	Eyes, Vision Change	
☐	☐	Ear, Nose, Throat, Mouth Problems	
☐	☐	Seizure	
☐	☐	Osteoporosis	
☐	☐	Numbness/Tingling	
☐	☐	Other Illness/Hospitalization	
☐	☐	Previous Bone or Joint Problems	
☐	☐	Other Sports Injury	
☐	☐	**PREVIOUS SURGERY** (type and dates)	
☐	☐	**PREVIOUS & FUTURE DENTAL PROCEDURES** (type and dates)	
☐	☐	**FAMILY HISTORY** (illness, reactions to anesthesia)	
☐	☐	**RECENT TEST RESULTS** (EKG, check x-ray, blood or HIV tests, etc.)	
☐	☐	**DRINK?** (how often?)	
☐	☐	**SMOKE** (pack/day)	

DRUG ALLERGIES (Check yes or no)

Yes	No	
☐	☐	If yes, provide details _____

LATEX ALLERGIES (Check yes or no)

Yes	No	
☐	☐	If yes, provide details _____

OTHER MEDICATIONS (current/recent)

Yes	No	
☐	☐	Diuretics
☐	☐	Blood Thinners
☐	☐	Steroids/Cortisone
☐	☐	Weight Control
☐	☐	Sleeping Pills
☐	☐	Antibiotics
☐	☐	Pain Pills
☐	☐	Aspirin
☐	☐	Anti-inflammatories (e.g. Advil)
☐	☐	Herbals/Vitamins/Supplements
☐	☐	Other

WOMEN ONLY

Pregnant? _____

Birth Control (type) _____

Date Last Period Started _____

For Office Use only	*Date / Initials*
History Reviewed / Updated	
History Reviewed / Updated	
History Reviewed / Updated	

Name: _____

DOB: _____

Chart: _____

Age: _____

Date: _____

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REVIEW OF SYSTEMS

NAME _____ DATE _____ CHART# _____

Please check which applies to you and describe, or check "No problem:"

General:
☐ No problem
☐ Fever ☐ Weakness ☐ Fatigue ☐ Headaches
☐ Recent weight changes

Skin:
☐ No problem
☐ Rashes ☐ Eruptions ☐ Dryness ☐ Jaundice
☐ Swelling ☐ Discoloration ☐ Changes in skin/hair/nails

Eyes:
☐ No problem
☐ Double vision ☐ Burning eyes ☐ Seeing spots

Ears/Nose/Throat:
☐ No problem
☐ Hoarseness ☐ Head colds ☐ Obstruction ☐ Nasal drainage
☐ Sinus pain ☐ Earache ☐ Hearing loss ☐ Hearing aids
☐ Difficulty swallowing ☐ Soreness/redness of gums

Musculoskeletal:
☐ No problem
☐ Joint pain ☐ Swelling ☐ Stiffness ☐ Deformity

Pulmonary:
☐ No problem
☐ Asthma ☐ Bronchitis ☐ Pneumonia
☐ Shortness of breath ☐ Difficulty breathing

Neurological:
☐ No problem
☐ Fainting ☐ Blackouts ☐ Paralysis ☐ Memory loss
☐ Dizzy spells

Cardiovascular:
☐ No problem
☐ Chest pain ☐ Leg swelling ☐ Varicose veins ☐ Heart attack
☐ Rapid heartbeat ☐ Rheumatic fever ☐ Heart valve problems

Endocrine:
☐ No problem
☐ Fatigue ☐ Hot or cold intolerance ☐ Excessive sweating, thirst, hunger

Gastrointestinal:
☐ No problem
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Heartburn ☐ Hemorrhoids ☐ Reflux ☐ Blood in stools
☐ Ulcers ☐ Decrease in appetite

Genitourinary:
☐ No problem
☐ Incontinence ☐ Blood in urine ☐ Urinary frequency/pain
☐ Difficulty voiding

Male:
☐ No problem
☐ Hernia ☐ Impotency ☐ Infertility ☐ Penile problems
☐ Testicular problems

Female:
☐ No problem
☐ Pain ☐ Discomfort ☐ Vaginal discharge

Hematological/Lymphatic:
☐ No problem
☐ Anemia ☐ Swollen glands ☐ Easy bruising or bleeding

Psychological:
☐ No problem
☐ Nervousness ☐ Mood swings ☐ Insomnia ☐ Nightmares
☐ Depression ☐ Irritability

Other:

Name: _____

DOB: _____

Chart: _____

Age: _____

Date: _____

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CLINICAL INFORMATION

What is being examined today? _____ ☐ Right ☐ Left Dominant Hand ☐ Right ☐ Left

How long have you had this problem? _____ Date pain started? _____

How did the problem first occur? _____

Have you seen a physician for this problem before? ☐ No ☐ Yes Doctor _____

Have you had a previous injury in this area? ☐ No ☐ Yes If yes, please describe _____

Have you had surgery on this area? _____

What physician did your surgery? _____

Sports/Hobbies _____ Level (e.g., High School, Recreational) _____

What makes your pain better? _____

What makes your pain worse? _____

Medications used for this problem: _____

Do you have Numbness and Tingling? _____

Do you have swelling? _____

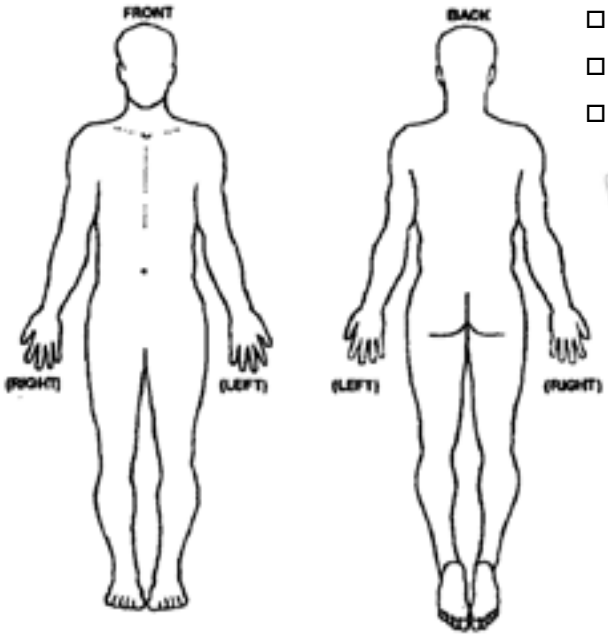
Have you had any tests for this problem? ☐ MRI ☐ X-Ray ☐ Other: _____

Does your pain radiate (move)? _____

Do you have weakness? _____

Pain Drawing:

Please indicate the locations of your pain with a "X":



Rate your pain: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Describe you pain check all that apply:

☐ Sharp	☐ Pins and needles	☐ Worse at night
☐ Aching / Throbbing	☐ Dull	☐ Getting better
☐ Burning	☐ Constant	☐ Unchanged
☐ Comes and goes	☐ Worse in morning	☐ Getting worse