

Date: _____

PATIENT INFORMATION

Chart #: _____

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

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____
 Sex _____ Birthdate ____/____/____ Age _____ SS# _____ - _____ - _____ Marital Status: S M W D
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____
 Cell Phone (____) _____ - _____ Email _____
 Employer/School Name _____ Employed: Full Time Part Time Student: Full time Part time
 Driver's License # & State _____ Primary Care / Family Physician's Name _____
 Have you ever been treated by one of our physicians? No Yes, by Dr _____ Approximate Date _____
 Was your injury sustained on the job? Yes No If yes, has a claim been filed with your employer? Yes No

EMERGENCY CONTACT

1st Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____
 2nd Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

REFERRED BY Doctor Hospital/Clinic Patient Friend/Co-Worker Family Member HMO/PPO Directory
 Employer Referral Service Yellow Pages Print Advertising TV Internet Radio School Other _____
 If referred by a physician: Last Name _____ First Name _____ Phone # _____
 If referred by another source, list specific name (i.e hospital, school, or friend's name) _____

PRIMARY INSURANCE (complete blanks below with *insured's* information)

Insured's Name _____
 Sex _____ Date of Birth _____ SS# _____
 Patient's Relationship to Insured _____
 Employer _____
 Employer's Address _____
 City _____ State _____ Zip _____
 Insurance Co Name _____
 Phone # (____) _____ - _____
 Claims Filing Address _____
 City _____ State _____ Zip _____
 ID# _____ Group # _____

SECONDARY INSURANCE (complete with *insured's* information)

Insured's Name _____
 Sex _____ Date of Birth _____ SS# _____
 Patient's Relationship to Insured _____
 Employer _____
 Employer's Address _____
 City _____ State _____ Zip _____
 Insurance Co Name _____
 Phone # (____) _____ - _____
 Claims Filing Address _____
 City _____ State _____ Zip _____
 ID# _____ Group # _____

GUARANTOR (if other than patient) Last Name _____ First Name _____ M.I. _____ Sex _____
 Birthdate _____ SS#: _____ - _____ - _____ Driver's License # & State _____ Relationship to patient _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.
ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to Austin Sports Medicine. **CONSENT FOR TREATMENT:** I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Date _____ Signature (patient, parent, or guardian) _____ Relationship _____

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 Practice reserves the right to change the Notice of Privacy Policies
- 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): _____

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 any 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 copayment 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 unscheduled services provided in the hospital. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of statement from our office.
- Your estimated portion of our fees for scheduled surgical procedures is due prior to the surgery date. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of statement from our office.
- We will look to the **adult accompanying** a minor for all services rendered to minor patients.

All surgery includes a 60- to 90-day period of postoperative office visits, as established by your health plan. This does not include x-rays, physical therapy, or durable medical prescribed.

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 Commission law to handle your claim with your employer's workers compensation insurance carrier (pursuant to TWCC Rule 120.1 & 120.2). Please mark the applicable statement:

_____ I certify that my injury/condition IS work related

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

SIGNATURE OF PATIENT or RESPONSIBLE PARTY IF A MINOR

PRINTED NAME

DATE

NAME _____ DATE ____ / ____ / ____ Chart# _____

ELBOW

Was this an injury or did it occur over time? _____

Date of injury or How long have you had this problem? _____

Where do you have the problem? _____

If an injury, describe how it occurred: _____

Have you had this or a similar problem before? Yes / No

If so, what problem and how was it treated? _____

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

Describe your pain (circle all that apply):

- | | | | |
|------------------|------------------|------------------|------------------|
| Sharp | Comes and goes | Constant | Intermittent |
| Aching | Pins and needles | Chronic | Unchanged |
| Stabbing | Explosive | Getting better | Getting worse |
| Dull | Electric | Worse in morning | Worse in evening |
| Constant burning | Throbbing | Unrelenting | Worse at night |

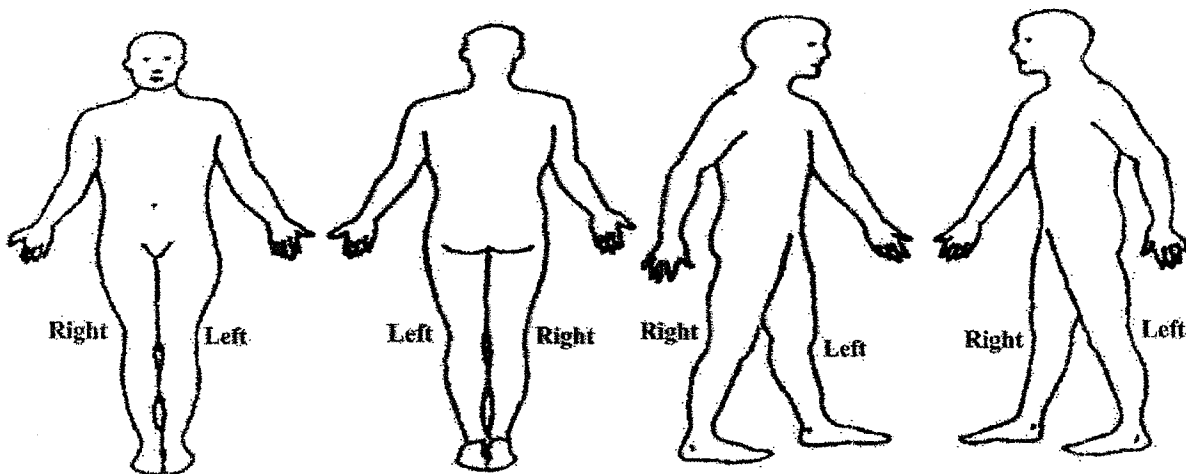
What makes your pain worse? _____

What makes your pain better? _____

Medications used for this problem: _____

Have you had any tests for this problem: MRI / Bone Scan / X-ray / Arthrogram / Other: _____

Please indicate the location(s) of your pain with an "X":



NAME _____ **DATE** ___ / ___ / ___ **Chart#** _____

Do you have numbness or tingling? Yes / No Where? _____

Do you have swelling? Yes / No Where? _____

Do you have instability or dislocations? Yes / No

Do you have popping / catching / grinding?

Do you have any weakness of grip? Yes / No

Do you have neck pain? Yes / No

Have you had any elbow surgery? Yes / No

Do you have any other problems not previously described? Yes / No

Please describe: _____

Referring Physician: _____

Other physicians you have seen for this problem: _____

Dates of work/school missed for this problem: _____

Is there an attorney involved with this problem? If yes, please provide additional information.

Patient Name: _____

Patient Signature: _____

Date: _____

MEDICAL HISTORY

Please complete all sections and indicate if non-applicable.

Name _____ Date _____ Age _____ Sex (Circle one) M / F

Primary Physician (provide first & last name) _____ Height _____ Weight _____

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

Yes	No	Details	Medication
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems/Pacemaker/Chest Pain _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Lung Disease/Shortness of Breath _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disorders _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems/Stroke _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/Phlebitis _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Bladder Infections _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer/Bleeding _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Vision Change _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat, Mouth Problems _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Illness/Hospitalization _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Previous Bone or Joint Problems _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Sports Injury _____	_____

DRUG ALLERGIES (Check yes or no)

Yes No
 If yes, provide details _____

LATEX ALLERGIES (Check yes or 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) _____

Herbs/Vitamins/Supplements _____

Other _____

Yes No

PREVIOUS SURGERY (type and dates) _____

FAMILY HISTORY (illness, reactions to anesthesia) _____

RECENT TEST RESULTS (EKG, chest x-ray, blood or HIV tests, etc.) _____

RECENT ILLNESSES OR SYMPTOMS _____

SMOKE? (pack/day) _____

DRINK? (how often?) _____

WOMEN ONLY

Pregnant? _____

Birth Control (type) _____

Date Last Period Started _____

Normal? _____

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

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person, except when you have authorized us to do so. I have read and answered completely and accurately.

SIGNATURE _____ DATE _____

