ARIZONA SPORTS MEDICINE CENTER

PHYSICIAN: Waslewski Freedberg Peterson Dean Sahasrabudhe **DATE:**_____
(Circle One)

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____ State:____ Zip:_____

Home#_____ Work#_____ Cell#_____ E-mail:_____

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Date of Birth:_____ Gender: Male Female Social Security#_____

Marital Status: (Circle One) Married Single Divorced Separated Widow(er)

Employer/School:_____

Employment Status: __Employed __FT __PT __Not Employed __Retired __Student __Active Duty

Emergency Contact:_____ Relation:_____ Phone:_____

Responsible Party/Insured Party Information (Please fill out completely if other than self)

Responsible Party: **Self** Last Name:_____ First Name:_____

Date of Birth:_____ SSN:_____ Relationship:_____ Gender: M F

Address:_____ City:_____ State:____ Zip:_____

Home#_____ Work#_____ Cell#_____ E-mail:_____

Responsible/Insured Party's Employer:_____

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Policy Holder:_____ Policy Holder:_____

Policy ID#_____ Policy ID#_____

Group#_____ Group#_____

Insurer's Address:_____ Insurer's Address:_____

If the primary policy holder is anyone other than yourself, please fill out Responsible Party/Insured Party Information above

□ I have read the financial policy:_____ (Signature)

Arizona Sports Medicine Center

Gary Waslewski, MD • Douglas Freedberg, MD • Charles Peterson, MD
Erik Dean, DO • Amit Sahasrabudhe, MD

Patient Name:_____ DOB:_____ Height:_____ Weight:_____
Today's ailment (brief description of onset):_____
_____
_____ Affected Side: Left Right
Date of injury or onset of problem:_____ Dominant Hand: Left Right
What is your occupation? _____
Work Related? □ Yes □ No Auto accident? □ Yes □ No Attorney involved? □ Yes □ No
Have you had x-rays taken? □ Yes □ No If yes, where? _____
Have you had an MRI? □ Yes □ No If yes, where? _____
Drug Allergies: □ Yes □ No Please list drug and reaction:_____
Primary Pharmacy:_____
Phone Number: _____
Fax Number: _____

Daily Medications (please include pain meds, herbs, vitamins, and OTC)

Name	Dosage/Strength	Times/Day

Past Surgical History (list type and date) :
_____
_____
_____
_____

Past Medical/Hospital History (Illnesses/Conditions):
_____
_____
_____
_____

Do you now or have you ever had?

Anemia	Yes	No
Diabetes	Yes	No
Cancer/Type:_____	Yes	No
Kidney/Bladder Trouble	Yes	No
High Blood Pressure	Yes	No
Heart Trouble	Yes	No
Bleeding Disorder	Yes	No
Asthma	Yes	No
Neurological Disorder/Seizures	Yes	No
Depression	Yes	No
Stroke	Yes	No
Thyroid Disorder	Yes	No
Ulcer/Stomach Problems	Yes	No
Hepatitis	Yes	No
Arthritis/Gout	Yes	No
Phlebitis/Blood Clots	Yes	No
AIDS/HIV	Yes	No
Substance Abuse	Yes	No

Do you exercise? □ Yes □ No How often?_____
What type? (running, biking, etc.)_____
Do you smoke? □ Yes □ No Packs per day:_____ For how many years?_____
Do you drink alcohol? □ Yes □ No If yes, average consumption per week?_____

Family History: Please list age and state of health

Adopted?	Yes	No
Father:	Age_____	_____
Mother:	Age_____	_____
Siblings:	____#Brothers	_____#Sisters
	Age_____	_____
	Age_____	_____
	Age_____	_____
Children:	_____#Sons	_____#Daughters
	Age_____	_____
	Age_____	_____
	Age_____	_____
	Age_____	_____

Are you now, or could you possibly become pregnant? □ Yes □ No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? □ Yes □ No
If yes, who and what is their age:
_____

Have you or any blood relative younger than 50 ever had a serious reacton to anesthesia? □ Yes □ No
If yes, who and what is their age:
_____

The above information is, to the best of my knowledge, a true statement of my current condition.

Patient Signature:_____ **Date:**_____

Patient Information (continued)

What are we seeing you for today? _____ Date of illness/injury:_____

May our office leave messages on your voice mail or answering machine regarding your healthcare, including but not limited to appointments, surgery, test results, or other necessary treatment information at the stated number on this form?

□ Yes □ No

May our office leave messages with family members, friends, or other individuals that answer a call placed at the stated number on this form?

□ Yes □ No

Authorization to Release Information: I hereby authorize Arizona Sports Medicine Center to release any information required in the course of my examination or treatment to the stated insurance companies.

Signed (Patient or Parent, if minor): _____ Date:_____

Authorization to Pay: I hereby authorize payment directly to the business office of Arizona Sports Medicine Center for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. In the even of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or Parent, if minor): _____ Date:_____

In order to control the cost of billing, Arizona Sports Medicine Center requests payment of all co-pays at the time of service.

_____ (Initial, if applicable) If you are **Self-pay**, please pay the balance in full at the time of service. In the event that you are unable to pay the balance in full, please advise us prior to time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collections.

Workman's Compensation, if applicable

Insurance Carrier:_____ Claim #_____ Date of Injury:_____

Address:_____ City:_____ State:_____ Zip:_____

Adjuster:_____ Phone:_____

Nurse Case Manager:_____ Phone:_____

_____ (Initial) We will bill your Worker's Compensation Carrier for your charges. Please note you will remain financially responsible for any and all charges should your carrier deny coverage or your claim is contested.

ARIZONA SPORTS MEDICINE CENTER
Summary of Privacy Practices

As of April 14, 2003 new federal laws mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is concerning patient privacy and access to medical records. The purpose of this brochure is to outline how these new laws affect you as a patient of Arizona Sports Medicine Center (ASMC).

Patient's Rights to Access Records

- You have a right to request to see your records or to request a copy of your records. Upon receipt of your written request, our Privacy Officer will contact you to make arrangements to review your records in the ASMC office or to copy the records you have requested.
- You have a right to request a written summary or explanation of your records. Upon receipt of your written request, our Privacy Officer will arrange for your physician to review and summarize your records.
- You have a right to inspect and request and amendment of your records. If, in reviewing your records, you find an inaccuracy in the facts documented or an omission, you have the right to submit an amendment to your record.
- You have a right to request a limited accounting of disclosures of your records. You may request an accounting of any of the disclosures of your health information to purposes other than treatment, payment, or healthcare administration.

Rights to Privacy

- You may request additional protections for sensitive health information or to limit disclosures of portions of your health information. In addition to the protections for Highly Confidential Information specified by HIPAA, you may request, in writing, that other sensitive information be protected. Our Privacy Office will take steps to implement these protections and to inform you of the limits of these steps.
- You may designate a personal healthcare representative. You may designate someone to act as your personal health representative. This person would have the same rights of access as you, for your health information. You may change your designated personal representative at any time.
- You have a right to request that your personal health information be communicated to you in a different manner or at a different location. You must make this request in writing.

Rights of Parents of Minor Children

As the parent or guardian of a minor child, you have the same rights of access to your child's records as to your own, with the following exceptions:

- Your rights to access of the minor child's records have been revoked or limited by a court of law
- Your minor child is an emancipated minor under the law
- Services are provided to your child under the regulations of the State of Arizona.

Your Responsibilities Under HIPAA

In order to safeguard your rights under HIPAA, you have a responsibility to keep ASMC informed of any changes that would affect the disclosure of your personal health information. You have an obligation to:

- Provide accurate information about your address, telephone number, and insurance coverage each time you visit.
- Report any changes in your personal health representative, emergency contact information, and structure of your family, etc.
- Respect the privacy rights of other patients.

Arizona Sports Medicine Center Responsibilities

Our first responsibility, as always, is to safeguard the health of our patients. If the provider believes any of the provisions of HIPAA could endanger your life or physical safety or that of another individual, the practice must act in accordance with this belief and do what is in the best interest of the patient.

We are also responsible for safeguarding your privacy. We have an obligation to keep you informed of any disclosures of your personal health information outside of those required for treatment, payment of services, and healthcare administration.

We also have an obligation to work with you to ensure your rights under HIPAA. Our Privacy Officer, with the support of all of the physicians and staff, will work directly with you to ensure your rights to privacy and to access under HIPAA.

Any patient believing his or her privacy rights have been violated may file a complaint with the Privacy Officer at ASMC or with the Secretary of Health and Human Services.

A complete copy of your privacy policy can be obtained at any of the reception areas in the Scottsdale, Tempe, or Gilbert offices, as well as, being posted on our web site. ASMC reserves the right to change the terms of this notice and to make the new terms apply to all protected health information it maintains.

Our Privacy Officer can be reached at: 480-558-3744

_____ _____

Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapaciated (physically or mentally), obtain the following signatures:

_____ _____ _____

Signature of Personal Representative Description of Authority Date

Gary L. Waslewski, MD
Douglas B. Freedberg, MD
Charles S. Peterson, MD
Erik J. Dean, DO
Amit A. Sahasrabudhe, MD

TO ALL PATIENTS:

If my account is over 120 days past due and I have not made a reasonable attempt to pay, a collection agency will be retained to collect payment for all monies due with an additional (35%) fee added to cover the cost of the collection agency and administrative costs. A (50%) fee will be added if legal costs are necessary.

_____ _____

Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapaciated (physically or mentally), obtain the following signatures:

_____ _____ _____

Signature of Personal Representative Description of Authority Date

CREDIT CARD FORM

VISA_____ MASTERCARD_____

Credit Card Number_____
Expiration Date_____
Card Holder's Name_____

After one statement, any patient balance due will be charged to your credit card. A final collection notice will be issued if not paid in full by due date.

_____ _____
Authorized Signature **Date**

Last name A-N will be charged between the 1st and 15th
Last name O-Z will be charged between the 16st and 30th

List other family members and their birthdates seen by this practice

Name: Birthdate:

_____
_____
_____
_____

For office use only: Patient Account #_____