Sievers Sports Medicine Demographics

Patient Name (last) _____(first)_____(M.I)_____ DOB_____/_____/_____ Age: _____

Gender: male_____ Female_____ **Marital Status**: S ___M ___W ___D ___Sep___

Address_____ Apt #_____City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

Patients SSN _____-_____-_____ Preferred Pharmacy_____

Employer/School _____Language Preference_____EMAIL: _____

How did you hear about us? _____ if person or doctor who? _____

If you are under the age of 18 then a parent MUST accompany you to your appt. and bring their ID. Bring any and all x-rays/imaging specific to the injury with you to the appt.

Spouse / guarantor, resp. party (last) _____(first)_____(initial)_____ DOB ____/____/_____

Employer/School _____Phone_____

Address (if diff. from above) _____ Apt # _____ City _____ State _____ Zip _____

Is this your emergency contact? _____Yes _____No If no List emergency contact with contact _____

Primary Insurance Policy Holders Name _____DOB ____/_____/_____SSN _____-_____-_____
Relationship to patient _____

Address if different from above_____ apt # _____ City _____State _____Zip_____

We MUST have this information to file your insurance. If you have secondary ins. We will need at time of visit. If you do not provide insurance we will not retro bill any visits.

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I give permission for medical treatment, including radiological and laboratory procedures to be performed by the physicians and staff of Sievers Sports Medicine. This consent is valued from this day forward. I authorize payments of medical benefits for Sievers Sports Medicine for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize Sievers Sports Medicine to disclose to any person or corporation, which is or may be liable under a contract to Sievers Sports Medicine, the physician(s), the patient, for all or part of Sievers Sports Medicine and physician charges, including but not limited to, insurance companies, workers' compensation carriers, and governmental agencies. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES**. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. MEDICARE AND/OR MEDICAID CERTIFICATION: "I certify that the information given by me in applying for payment under Title XCIII and/or Title XIX of the Social Security Administration is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or it's inter-me diaries/carriers any information needed for this or related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf.

PATIENT RECORD OF DISCLOSURES In general, HIPAA privacy rule gives individuals the right to request a restriction of users and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of that communication, of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. My records/results can be released to

1) Myself only _____
2) List any other person/s you wish your PHI to be released to _____ Best way to be contacted
   - Phone if different from above_____
   - Written Communication _____
   - EMAIL: _____

Print Name _____Sign Name _____Date _____/_____/_____

Sievers Sports Medicine Patient Financial Responsibility PLEASE READ AND SIGN ALL AREAS REQUESTED

Dear patient: Thank you for choosing **Sievers Sports Medicine** for your healthcare. We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

INSURANCE: You are directly responsible for payment of your medical care and you are expected to pay for any co-payment, deductible, or non-covered amounts AT THE TIME OF SERVICE. Your insurance company may not pay for all of your health care costs. Insurance policies exclude some non-covered services; however, this does not mean that the services or test are not necessary. It means that the insurance company may not pay for it. Please keep in mind that your insurance policy is a contract between you and the insurance company. *The physician has no control over which services the insurance company does or does not cover.* In order to bill your insurance company, you MUST provide our office with accurate billing information and your insurance card/s. If you do not provide this information at each visit, please expect to pay in full at the time of the office visit for the services rendered. We reserve the right to re-schedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in**.**

BILLING: As a courtesy to you, we will bill your insurance company for the services rendered. In order to do so, we MUST have complete billing information, picture identification, and your insurance card. If your insurance changes it is your responsibility to provide us with updated insurance information. In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts are usually higher. Your insurance policy, not our office, determines these amounts. You will receive a statement every month from our office showing your account balance. Patient balances are due and payable in full upon receipt of your statement. Delinquent accounts will be transferred to a collection agency when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years**.**

WORK RELATED or MOTOR VEHICLE ACCIDEN (MVA): We do NOT file health Ins. For work related injury/problems, or MVA's. If this is found to be a work-related injury/problem or MVA and your INS denies payment at any time YOU will be financially responsible for the charges not covered and/or denied by your INS.

REFERRALS: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be re-scheduled or you may be financially responsibility. Specific coverage issues, however should be directed to your insurance company member services department (number is on insurance card). Please understand that maintaining financial responsibility is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enable us to deliver the quality healthcare you deserve and expect.

HIPAA Acknowledgement I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that his information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment; directly or in directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand the Notice of Privacy Practices for Sievers Sports Medicine containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. **I understand that** I may request, in writing that you restrict how many private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. **I understand that** I may revoke this consent at any time, except to the extent that you have taken action relying on consent. If you have any questions about this notice please contact.

If you have any questions, please talk to our staff before signing. Print Patient's Name _____

Patient/Guardian Signature _____ Date _____/_____/_____

SIEVERS SPORTS MEDICINE
& FAMILY PRACTICE

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Name_____ Today's Date_____

☐ Male ☐ Female Age_____ Birthdate_____ Date of last physical examination_____
mm / dd / yyyy

Marital status_____ Occupation_____

What is the reason for your visit today?_____

HEALTH MAINTENANCE *List the most recent date for each of the following:*

WOMEN ONLY	BOTH MEN AND WOMEN		MEN ONLY
_____Menstrual period	_____Cholesterol testing	_____Pneumonia vaccine	_____Digital rectal exam
_____Mammogram	_____Colonoscopy	_____Bone Density (DEXA)	_____PSA (prostate blood test)
_____Pap smear	_____Tetanus booster		

CONDITIONS *Check ☑ conditions you currently have or have had in the past*

☐ AIDS	☐ Bronchitis	☐ GERD (reflux)	☐ HIV positive	☐ Rhinitis
☐ Alcoholism	☐ Bulimia	☐ Glaucoma	☐ Kidney disease	☐ Sexually transmitted infection
☐ Anemia	☐ CAD / heart disease	☐ Goiter	☐ Liver disease	
☐ Anorexia	☐ Cancer, type_____	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anxiety	☐ Chemical dependency	☐ Headaches	☐ Pacemaker	☐ Suicide attempt
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Pneumonia	☐ Thyroid problem
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Prostate problem	☐ Tuberculosis
☐ Bleeding disorder	☐ Emphysema/COPD	☐ Herpes	☐ Psychiatric care	☐ Ulcer(s)
☐ Breast lump	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever	☐ Vaginal infections
☐ Severe sprains	☐ Broken Bones	☐ Seizures	☐ Other	

ALLERGIES? *Check ☑ appropriate box below. If yes, please list all known allergies to medications or substances*

☐ No known allergies ☐ Yes, I have the following allergies:

MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

HEALTH HABITS *Check ☑ appropriate boxes below and describe*

Caffeine	☐ None	☐ _____ drinks per _____	
Tobacco	☐ None	☐ _____ cigarettes per day	☐ Quit smoking around _____
Alcohol	☐ None	☐ _____ drinks per _____	
Drugs	☐ None	☐	
Diet	Describe:		
Exercise	Describe:		
Seat belts	☐ Always	☐ Never	☐ Sometimes

(Continued on back)

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery / complications, if any

PREGNANCY HISTORY

pregnancies_____ ; # living children _____

deliveries: C-sections_____ ; vaginal _____

Birth year	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

Have you ever had a blood transfusion? ☐No ☐Yes Date(s):

FAMILY HISTORY

Fill in information about your family below:

Check ☑ if a blood relative has had any of the following:

Relation	Age, if living	Age at death	Medical conditions / cause of death	Disease	Relationship to you
Father				☐ Arthritis	
Mother				☐ Asthma	
Brothers				☐ Cancer	
				☐ Diabetes	
				☐ Gout	
				☐ Heart disease	
Sisters				☐ High blood pressure	
				☐ Kidney disease	
				☐ Stroke	
				☐ Other	

ADDITIONAL INFORMATION

What else do you think your doctor should know about your health?

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ Reviewed by_____ Date_____

Payment

As the patient you are responsible for payment of your medical care. We are happy to bill your insurance as a courtesy to you as long as ***you*** provide ***ANY*** and ***ALL*** insurance (primary, secondary, tertiary). If you do not provide this information prior to your appointment or at the time of your appointment you will be responsible for the full payment. Please note: if changes occur with your insurance, you must provide that to our office prior to your appointment if you still wish us to provide this service. Your insurance company may not pay for all of your healthcare cost. **Copayments, deductibles, and balances are due at the time of the visit unless previous arrangements have been made**. Sievers Sports Medicine is not in control of your insurance plan. That is contract between you and your insurance company.

Note: We have no way of knowing what insurance/s you have therefore, you, the patient is responsible for providing this information. **Please be prepared to show your insurance card at every visit.**

_____ _____

Patient/Guardian **Print and Sign** Date

NO SHOW AND CANCELLED APPOINTMENT/INJECTION POLICY

We understand that there are times when you may miss an appointment due to emergencies for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Equally, the situation may arise where another patient fails to cancel and we are unable to schedule **YOU** due to a seemingly full schedule. If an appointment is not cancelled at least 24 hours in advance, you will be charged a $40.00 fee. This will not be covered by your insurance and must be paid prior to further treatments. Our phone number is **575-226-3023**

If you arrive to your appointment without your ID, Insurance card, previous X-Rays, CT's, MRI's, ETC and we have to reschedule you the above fee may also apply. It is **YOUR** responsibility to come prepared.

_____ _____

Patient/Guardian **Print and Sign** Date