HOT SPRINGS SPORTS MEDICINE

"We Keep ***You*** Moving!"

Patient Information Form

Name: _____ *(For Office Use Only)*

Address: _____ ***New Patient:*** ☐ Yes ☐ No

City, State, Zip: _____ ***Insurance Card & ID:*** ☐ Yes ☐ No

Home Phone: _____ Cell: _____ SS Number: _____

DOB: _____ Gender: M F Marital Status: ☐ Single ☐ Married ☐ Other

Employer: _____ ☐ NA Phone: _____ Status: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Appointment Reminders: ☐ **Text** *Cellular Carrier*: _____

☐ **Email** *Email Address*: _____

Primary Insurance Policy Holder Information: ☐ NA, I do not have medical insurance

Insurance: _____ Policy #: _____ Group #: _____

Policy Holder Name: ☐ Self / _____ Relationship to Patient: _____

If Not Self:

Policy Holder SS#: _____ Policy Holder DOB: _____Gender: M F

Effective Date of Coverage: _____ Primary Care Physician or Group: _____

Secondary Insurance Policy Holder Information: ☐ NA, I do not have medical insurance

Insurance: _____ Policy #: _____ Group #: _____

Policy Holder Name: ☐ Self / _____ Relationship to Patient: _____

If Not Self:

Policy Holder SS#: _____ Policy Holder DOB: _____Gender: M F

Effective Date of Coverage: _____ Primary Care Physician or Group: _____

Worker's Compensation (WC) Information: ☐ NA, I was not injured on my job

WC Insurance: _____ Case/Claim/Auth #: _____

Case Manager: _____ Phone: _____

Notified your medical insurance carrier that you've had an on-the-job accident? ☐ Yes ☐ No

Personal Injury / Automobile Accident Information: ☐ NA, this does not apply to me

Insurance: _____ Case/Claim/Auth #: _____

Case Manager: _____ Phone: _____

Notified your medical insurance carrier that you've had an accident? ☐ Yes ☐ No

Signature: _____ Date: _____

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Medical History Form

Name: _____ ACCOUNT #: _____

Please describe the injury/problem/issue(s) that brought you to Hot Springs Sports Medicine today:

What aggravates your injury/problem/issue?

What eases the symptoms of your injury/problem/issue?

Functional Status: (List any activities, home and work, that are difficult for you that are not mentioned above)

Living Situation: ☐ Alone ☐ With Family ☐ With Friends ☐ Other: _____

Surgeries/Date: ☐ NA

1. _____/_____ 3. _____/_____
2. _____/_____ 4. _____/_____

Diagnostic Tests: ☐ NA ☐ X-RAYS ☐ MRI ☐ CT Scan ☐ Other: _____

My overall health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medical History: (Please check all that apply)

☐ Anemia	☐ Cancer: _____	☐ Hearing	☐ MRSA	☐ Spinal Stenosis
☐ Alcohol/Drugs	☐ Depression	☐ Heart	☐ Muscle/Weakness	☐ Stomach Ulcers
☐ Arthritis	☐ Diabetes	☐ Hepatitis B / C	☐ Neuropathy	☐ Stroke
☐ Back Pain	☐ Ear/Nose/Throat	☐ HIV/AIDS	☐ Night Sweats	☐ Swallowing
☐ Balance Problem	☐ Fainting	☐ Infection	☐ Open Wounds	☐ Thyroid
☐ Bleeding	☐ Falls	☐ Intestinal	☐ Osteoporosis	☐ Tuberculosis
☐ Blood Clots	☐ Fever	☐ Joints	☐ Pancreatitis	☐ Vision
☐ Blood Pressure	☐ Fractures	☐ Kidneys	☐ Prostate	☐ Weight Change
☐ Blood Transfusion	☐ Gallstones	☐ Liver	☐ Seizures	☐ _____
☐ Bowel/Bladder	☐ Gynecologic	☐ Lung	☐ Skin	☐ _____
☐ Brain Injury	☐ Headaches	☐ Memory	☐ Speech Problems	☐ _____

☐ Pregnant How many weeks? _____ ☐ Pacemaker ☐ with defibrillator

Current Medications: ☐ NA _____

_____

Allergies: ☐ NA _____ ☐ Latex Sensitivity

Signature: _____ Date: _____

Information Reviewed By: _____ Date Reviewed: _____

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Patient Authorizations Form

Name: _____ ACCOUNT #: _____

Consent for Evaluation and Treatment:

I hereby authorize evaluation and treatment by Hot Springs Sports Medicine. My signature below reflects my consent for treatment.

No-Show and Cancellation Policy:

Please be advised that Hot Springs Sports Medicine requires a 24-hour notice of cancellation as a courtesy to us and our other patients. Hot Springs Sports Medicine reserves the right to charge a $25.00 no-show fee, per occurrence.

HIPAA Privacy Practice Notification:

I agree that I have been informed of the HIPAA Notice of Privacy Practices for Hot Springs Sports Medicine. I fully understand that I am in no way to discuss any information I hear or see about a patient or client that I may observe while being treated at Hot Springs Sports Medicine. For full details of how HIPAA protects you and other patients/clients receiving services at Hot Springs Sports Medicine, please visit our website to view and/or download a copy of our *HIPAA Notice of Privacy Practices*.

Consent to Release Medical Information:

I hereby authorize Hot Springs Sports Medicine to release any medical information pertaining to my care to my physician(s) for the purpose of securing reimbursement for the services rendered to me by Hot Springs Sports Medicine. I also authorize Hot Springs Sports Medicine to receive any pertinent information from my physician(s) or other medical service providers related to my treatment. In addition, I authorize the release of my medical information to the parties listed below:

Name/Relationship: _____/_____ Form of Contact Allowed: _____

Name/Relationship: _____/_____ Form of Contact Allowed: _____

Name/Relationship: _____/_____ Form of Contact Allowed: _____

Name/Relationship: _____/_____ Form of Contact Allowed: _____

Name/Relationship: _____/_____ Form of Contact Allowed: _____

I have read and fully understand and agree to the contents of this Patient Authorizations Form. I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent and agreement to the terms stated in this document.

Signature: _____ Date: _____

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Patient Financial Authorizations Form

Name: _____ ACCOUNT #: _____

Financial Policy:

I understand that Hot Springs Sports Medicine has verified my benefits as a courtesy to me prior to my initial appointment. This authorization is not a guarantee of payment. Any patient payment responsibility, such as a deductible, co-pay, or co-insurance, will be collected at the time of service. My signature below certifies that my benefits and financial responsibilities have been explained to me and I understand that I may be responsible for balances incurred after my insurance has been billed (if applicable). If I am a Medicare recipient, I have been given a copy of the ABN (Advanced Beneficiary Notice of Non-Coverage) and ABN instructions.

Consent for Assignment of Benefits: ☐ NA if Self-Pay

I hereby authorize Hot Springs Sports Medicine to bill my insurance company, and for my insurance company to remit payments directly to Hot Springs Sports Medicine for services rendered.

I have read and fully understand and agree to the financial obligations and terms stated above. I am the patient or am authorized to act on behalf of the patient to sign this document.

Signature: _____ Date: _____

Financing Service Options: (Our Healthcare Navigator will meet with you after your initial appointment to explain these options and how they may assist you in managing your financial responsibilities)

Compleat Rehab & Sports Therapy offers two healthcare financing services:

Care Credit

- May finance up to 100% of out-of-pocket
- Finance charge – Interest-Free if paid off within the promotional period
- Full-Payment term: Varies
- Credit approval required

United Medical Credit

- May finance up to 100% of out-of-pocket
- Funds deposited directly to bank account
- Finance charge – varies based on credit rating
- Full-Payment term: Within 24 months
- Credit approval required

Self-Pay Options:

- Initial Evaluation $90.00
- Non-Bundled Visit $70.00
- 3 Visit Bundle $195.00 ($65.00/visit)
- 6 Visit Bundle $360.00 ($60.00/visit)
- 12 Visit Bundle $600.00 ($50.00/visit)

Option Selected: ☐ None ☐ Care Credit ☐ United Medical ☐ 3 Visit Bundle ☐ 6 Visit Bundle ☐ 12 Visit Bundle

Healthcare Navigator Approval: _____ Date: _____