SPORTS MEDICINE INSTITUTE
2020 Oakley Seaver Drive
Clermont, FL 34711
352-242-0404

PATIENT INFORMATION: (please print)

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
Mailing Address: _____ **City:** _____ **State:**_____ **Zip:** _____
Home phone #: (_____) _____**Work phone #:** (____) _____**Cell #:** (____) _____
E-mail: _____ **Birthdate:** ____/____/____ **Sex:** ☐ M ☐ F
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow **Social Security Number:** _____
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Decline
Native Language: ☐ English ☐ Spanish ☐ Other: _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Family Physician: _____ **Phone #:** (____) _____
Referring Physician: _____ **Phone #:** (____) _____
For appointment reminders, indicate your preferred method: ☐ call home phone # ☐ call cell phone #

May we leave a detailed message on your voicemail or answering machine? ☐ Yes ☐ No

PATIENT EMPLOYMENT INFORMATION
☐ Employed ☐ Retired ☐ Unemployed
Employer's Name: _____
Employer's Phone #: _____
Occupation: _____

EMERGENCY CONTACT INFORMATION
Name:_____
Phone #: (____) _____
Relationship: _____

RESPONSIBLE PARTY: (complete only if the patient is under 18 years of age)
Name: _____ Employer: _____
Address: _____ Relationship: _____
City/State/Zip: _____ SSN: _____ Date of Birth: ____/____/____
Home ph #: (_____) _____ Work ph #: (_____) _____ Cell ph #: (_____) _____

AREA TO BE EXAMINED: _____ ☐ RT ☐ LT
Date of Injury: ____/____/____ ***PLEASE COMPLETE THE NEXT PAGE IF YOUR CONDITION IS FROM AN INJURY***
(If there was no injury, draw a line through the next form- the Injury Questionnaire)

INSURANCE AUTHORIZATION AND ASSIGNMENT: I attest that the information I have given here is correct and true to the best of my knowledge. I authorize Sports Medicine Institute to bill and collect payment(s) from my insurance carrier(s) and to release information necessary for the purpose of collecting such payments. I authorize my insurance company to pay direct to SMI for their services. I understand it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf. I understand and agree that I am responsible for any amount not paid by my insurance with the exception of contractual agreements and other disallowed charges. I agree to inform SMI regarding any changes in my personal billing information or my insurance billing information.

Patient/parent or guardian signature: _____ **Date:** ____/____/____

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INJURY QUESTIONNAIRE

Today's Date: ____/____/____

Patient Name: _____ **Birthdate:** ____/____/____

Due to increased billing & coding requirements from insurance companies, we need more in-depth information regarding your injury. Please complete the appropriate section below.

Do you have an attorney for this injury: ☐ yes ☐ no

Attorney name: _____ Phone #: (_____) _____-_____

SPORTS INJURY

Date of injury: _____/_____/_____

I was injured playing: ☐ baseball ☐ basketball ☐ football ☐ soccer ☐ golf

☐ Other: _____

Location of injury: ☐ athletic field ☐ home ☐ school ☐ other: _____

INJURY AT HOME OR ELSEWHERE (but not auto or work related)

Date of injury: _____/_____/_____

I was injured at: ☐ home ☐ other _____

Description of injury: _____

AUTOMOBILE ACCIDENT

Date of injury: _____/_____/_____ Accident happened on the interstate: ☐ yes ☐ no

It was in my own vehicle: ☐ yes ☐ no I was the ☐ driver ☐ passenger

Automobile Insurance: _____ Agent name/ph #: _____

WORK INJURY

Date of injury: ____/____/____ Employer at the time of injury: _____

Insurance company: _____ Claim #: _____

Claim adjuster name & Phone #: _____

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PATIENT NAME: _____ **Birthdate:** ____/____/____

CURRENT PROBLEM:
How long have you had this problem? (specify a number) ____days ____weeks ____months ____ years
How would you describe the pain? (mild, moderate, severe, stabbing, throbbing?) _____
On a scale of 0 to 10 (with 0 being no pain and 10 severe pain) please circle you pain level 0 1 2 3 4 5 6 7 8 9 10

What treatment have you had for this problem: ☐ Anti-inflammatory medication ☐ Injections ☐ Therapy
☐ Surgery ☐ no treatment ☐ Other: _____

General question: Are you right handed: ☐ Are you left handed: ☐

DID YOU COMPLETE THE PATIENT HISTORY FORM ON THE PATIENT PORTAL? ☐ Yes ☐ No
If YES, skip to page 5 and continue with "DO YOU HAVE AN ADVANCED CARE PLAN" question and continue

PAST MEDICAL HISTORY (please circle "Y" for yes and "N" for no and write any comments on the line)

Alcoholism	Y / N	_____
Anemia	Y / N	_____
Arthritis	Y / N	_____
Bleeding Disorder	Y / N	_____
Cancer	Y / N	_____
Diabetes	Y / N	_____
Gout	Y / N	_____
Heart Trouble	Y / N	_____
High Blood Pressure	Y / N	_____
Kidney Trouble	Y / N	_____
Lung Disease	Y / N	_____
Mental Illness	Y / N	_____
Phlebitis	Y / N	_____
Seizures	Y / N	_____
Stomach Ulcer(s)	Y / N	_____
Stroke	Y / N	_____
Thyroid Trouble	Y / N	_____
Tuberculosis	Y / N	_____
Liver Trouble	Y / N	_____
Other Illness/Injuries	Y / N	_____

Please list all past surgeries: _____
_____
_____
Please list allergies to medications. *If there are no known allergies, please check the box*: ☐
_____
Are you allergic to metal? Y / N if yes, elaborate: _____
_____
Any other medical history we should be aware of? If so, please elaborate: _____
_____

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MEDICATION LIST

Today's Date: ____/____/____

PATIENT NAME (please print): _____ **Birthdate**: _____/_____/_____

PREFERRED PHARMACY: _____ **Pharmacy Phone #:** (_____) _____-_____

MEDICATION	Strength/mg	# of pills per day	MEDICATION	Strength/mg	# of pills per day
Advair			Lyrica		
Albuterol			Meloxicam		
Aleve			Metformin		
Allopurinol			Methocarbamol		
Amitriptyline			Metoprolol		
Amlodipine			Multi-Vitamins		
Aspirin			Naproxen		
Atenolol			Niaspan		
Ativan			Omeprazole		
Atrovent			Oxycodone		
Baclofen			Paxil		
Benicar			Pepcid		
Calcium			Plavix		
Carisoprodal			Potassium		
Celebrex			Pravastatin		
Citalopram			Prilosec		
Clonidine			Protonix		
Coumadin			Ramipril		
Crestor			Ranitidine		
Cyclobenzaprine			Sertraline		
Diazepam			Simvastatin		
Diclofenac			Synthroid		
Digoxin			Tizanidine		
Effexor			Toprol		
Fish oil			Tramadol		
Flomax			Trazodone		
Flovent			Tylenol		
Fluoxetine			Xanax		
Fosamax			Zoloft		
Furosemide			Zolpidem		
Gabapentin			**ADDITIONAL MEDICATIONS**		
Glipizide					
Hydrochlorothiazide (HCTZ)					
Hydrocodone					
Ibuprofen					
Imitrex					
Insulin			**DO YOU HAVE ANY OF THESE?**		
Klor-Con			Pacemaker	Yes	No
Lantus			Aneurysm Clips	Yes	No
Lasix			Cochlear Implant	Yes	No
Levothyroxine			Spinal Stim Implant	Yes	No
Lexapro			Other implants:		
Lipitor					
Lisinopril			Verified by:		
Losartan			Verified with:		
Lovastatin			Date verified: _____/_____/_____		

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PATIENT NAME: _____ **Birthdate:** ____/____/____

FAMILY MEDICAL HISTORY
If unaware of family medical history (e.g. if you are adopted) please initial here and skip this section: _____

Alcoholism	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Arthritis	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Bleeding Disorder	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Cancer	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Diabetes	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Gout	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Heart Trouble	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
High Blood Pressure	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Kidney Trouble	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Mental Illness	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Seizures	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Stroke	Y / N	if yes, which side?	Maternal: Y / N	Paternal: Y / N
Other Illness/Injuries	Y / N	Explain: _____		

SOCIAL HISTORY: Please complete or indicate the following information:
Have you ever used alcohol products? Y / N If yes, do you still? Y / N
If yes & current, how many drinks per day? _____
Have you ever used tobacco products? Y / N If yes, do you still? Y / N
If yes & current, how many packs or cans per day? _____
Have you ever used illegal drugs? Y / N If yes, do you still? Y / N
If yes & current, how much per day? _____

***DO YOU HAVE AN ADVANCED CARE PLAN: ☐ Yes ☐ No
If yes, who is your designated surrogate: _____

REVIEW OF SYSTEMS: Please indicate any symptoms you are currently experiencing

____ Fever	____ Cough	____ Pigmentation Changes
____ Weight Loss	____ Diarrhea	____ Muscular Weakness
____ Weight Gain	____ Constipation	____ Incoordination
____ Eye Discomfort	____ Abdominal Pain	____ Loss of Balance
____ Changes in vision	____ Blood in Stool	____ Muscle Cramps
____ Headaches	____ Hemorrhoids	____ Cold Intolerance
____ Ear Pain	____ Urinary Frequency	____ Heat Intolerance
____ Hoarseness	____ Painful Urination	____ Anxiety
____ Chest Pain	____ Blood in Urine	____ Depression
____ Irregular Heartbeat	____ Difficulty Voiding	____ Easy Bruising
____ Shortness of Breath	____ Rash	____ Easy Bleeding
		____ Frequent Illnesses

WOMEN ONLY:
Irregular Periods Y / N Vaginal Discharge Y / N Frequent Spotting Y / N
ARE YOU CURRENTLY PREGNANT Y / N If yes, Due date: ____/____/____

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PATIENT NAME: _____ Birthdate: ____/____/____

CONSENT FOR TREATMENT

I hereby give consent to the SPORTS MEDICINE INSTITUTE to provide medical consultation and treatment for the area to be examined listed on page 1. I understand that I may, at any time, revoke this consent by providing written notice to the SPORTS MEDICINE INSTITUTE. Furthermore, I certify that all information furnished is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

RECORDS RELEASE AUTHORIZATION

I authorize the SPORTS MEDICINE INSTITUTE to release any private health information believed necessary to further my treatment or care. I realize I may revoke this consent by providing written notice to the SPORTS MEDICINE INSTITUTE. I realize by asserting this right, I may become responsible for coordinating my own care, including authorizations and payments for services needed.

INFORMATION RELEASE CONSENT FORM

To protect your privacy, we need you to provide us a list of family/friends that we can release your information to. If you do not want any information released to anyone, please draw a line through this section of the form.

*I give SPORTS MEDICINE INSTITUTE permission to discuss and/or release any and all confidential information of any kind, (personal, medical, financial-anything & everything) that they have in their possession regarding myself to the following people: (*please print names*)*

1. _____ Relationship: _____
2. _____ Relationship: _____

This is to include information regarding HIV (aids virus), STD (sexually transmitted diseases), pregnancy testing/reproduction and or sexuality rights, psychiatric disorders/mental health and drug/alcohol abuse. (see Note below)

APPOINTMENT & NO SHOW POLICY

Please be aware that appointments may be scheduled after yours. Therefore we cannot guarantee your appointment if you are more than 15 minutes late.

Office appointments that are cancelled with less than 24 hours notice will be subject to a $50 cancellation fee. If you do not show up for an appointment, without calling ahead, you are considered a NO SHOW. If you have two NO SHOWS within twelve months, you may be dismissed from the practice and denied any future visits. If you have been charged a no show fee, *it must be paid* before being seen by any of providers in the future. We understand there may be unavoidable circumstances. Fees in this instance may be waived but only with management approval.

Patient/Guardian Signature: _____ Today's Date: ____/____/____

Note: This release shall remain valid for one year from the date of signature or until it is revoked in writing.

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FINANCIAL POLICY

It is our goal to provide you the best orthopedic care we possibly can. Please understand that part of your care includes the billing of your insurance-provided we've received the correct and complete information from you.

Please read the following information as it will answer many of your questions regarding our billing policies.

For patients who have no insurance:

- Patients who have no insurance are expected to pay for services rendered at the time of the appointment
- CareCredit may be another option for payment: discuss this with our billing staff

For patients who currently are covered by insurance:

- The patient is responsible to provide us with valid health insurance information and should bring their active insurance card(s) to every visit.
- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services.
- We bill secondary insurances as a courtesy (if we are provided with that complete information).
- CareCredit may be another option for payment: discuss this with our billing staff

If you have an insurance plan that we are in network or contracted with:

- The patient is responsible to pay any co-payment owing at the time of the visit. Your appointment may be rescheduled if you did not bring your co-payment with you.
- Any medical services not covered by your insurance plan are the patient's responsibility. If you have specific coverage questions, contact your insurance company directly using the phone number listed on the back of your card. CareCredit may be an option to consider for any balances: discuss this with our billing staff
- Our billing department is available to assist you with your billing questions.

If you have an insurance plan that we are out-of-network or not contracted with:

- We will file a claim with your insurance company, however generally you will have a higher "out of pocket" expense.
- Our billing department is available to assist you with your billing questions.

If you are covered by an HMO or Managed Care Plan:

- The patient is responsible to pay any co-payment or any portion of the charges as specified by the plan at the time of the visit.
- The patient is responsible to ensure that any required referral for treatment is provided to the practice no later than at the time of the visit. Without a current referral, your appointment may need to be rescheduled or you will be financially responsible for the charges for that treatment or visit.

If you have a current Workman's Comp claim or were hurt at work:

- Your initial appointment needs to be made by your claims adjuster.

_____ ____/____/____ ____/____/____

Signature (guarantor if patient is a minor) *Printed Name* *Patient birthdate* *Date*

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HIPAA NOTICE OF PRIVACY PRACTICES

I consent to the use of my protected health information by Sports Medicine Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of SMI.

I have the right to revoke this consent, in writing, at any time, except to the extent that SMI has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Notice of Privacy Practices (NPP) for SMI prior to signing this document and it will be made available to me upon request. The NPP describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of SMI. The NPP for SMI is also provided at the front desk. The NPP also describes my rights and SMI's duties with respect to my protected health information.

Electronic Format: *I acknowledge that my records are stored in an electronic format. I understand SMI maintains their patient records in an electronic format except for patients who have not been seen since the conversion to electronic medical records. Original documents are destroyed after being converted to electronic format.*

SMI reserves the right to change the privacy practices that are described in the NPP.

I understand the information presented above in regards to my medical information and that I have the right to obtain a complete copy of the Notice of Privacy Practices.

_____ ____/____/____ ____/____/____

Patient Signature *Printed Name* *Patient birthdate* *Todays date*

MISCELLANEOUS INFORMATION

Completion of Private insurance forms:

- We charge $10 PER FORM which is to be paid at the time the form is left at our office. For additional forms from the same company, there is no charge. Please allow up to 7 days for the form to be completed AND COMPLETE ALL OF YOUR INFORMATION FIRST.

Copies of your records or x-rays:

- There may be a charge for any duplication of records and/or films

Treatment of a minor child:

- If your child is less than 18 years of age, a parent or legal guardian must accompany them to their initial visit. The accompanying adult is responsible for payment of the account per the FINANCIAL POLICY information.

_____ ____/____/____ ____/____/____

Patient Signature *Printed Name* *Patient birthdate* *Todays date*