

Name:  
DOB:  
Chart:  
Age:  
Date:



AUSTIN  
SPORTS  
MEDICINE

900 West 38<sup>th</sup> Street , Suite 300  
Austin, TX 78705-1130  
512-450-1300 Fax 512-450-1339  
[www.austinsportsmed.com](http://www.austinsportsmed.com)

### 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 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 all services provided in the hospital. Any balance remaining after your health plan pays is your responsibility. Payment is due upon receipt of a statement from our office.
- A surgery deposit will be required prior to your surgery date. We will estimate the surgeon's fees, not covered services, as well as the expected payment from your insurance company to determine the deposit amount. After your insurance company has paid our office and the actual patient responsibility is calculated you will be billed for amounts due or refunded amounts that you have overpaid. PLEASE NOTE THAT THIS ESTIMATE DOES NOT INCLUDE CHARGES FROM THE HOSPITAL, SURGERY CENTER, ANESTHESIA, PATHOLOGY, RADIOLOGY, LAB, ETC. YOU WILL RECEIVE SEPARATE BILLS FROM THESE ENTITIES FOR THIER SERVICES.
- We will look to the **adult accompanying** a minor for all services rendered to minor patients.
- Most surgeries include a 10-90 day period of covered postoperative office visits known as the "Global Period" as established by your health plan. This does not include x-rays, physical therapy, or durable medical equipment that may be prescribed.
- If you have a balance on your account, you will receive a total of three statements. Should your account become more than 90 days past due, your account will be sent to a collection agency.

***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.***

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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 law to handle your claim with your employer's workers compensation insurance carrier (pursuant to TWCC Rule 120.1 & 120.0). Please mark the applicable statement:

\_\_\_\_\_ I certify that my injury/condition IS work related

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

Name:  
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## AUSTIN SPORTS MEDICINE

### PATIENT INFORMATION

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

Today's Date \_\_\_\_\_

#### Patient Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status: S M W D

Social Security No. \_\_\_\_\_ Driver's License State and # \_\_\_\_\_

Permanent Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Preferred Language \_\_\_\_\_ Race:  Decline  Asian  African American  Caucasian  Native American

Ethnicity:  Decline  Hispanic or Latino  Non Hispanic or Latino

Smoking Status:  Current Smoker  Former Smoker  Non-Smoker Start Date \_\_\_\_\_ Stop Date \_\_\_\_\_

Occupation \_\_\_\_\_ Employer/School Name \_\_\_\_\_

Primary Care / Family Physician's Name \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_ Address or Intersection \_\_\_\_\_

Have you been treated by one of our physicians?  No  Yes by Dr. \_\_\_\_\_ Approximate Date \_\_\_\_\_

Was your injury sustained on the job? \_\_\_\_\_ Has a claim been filed with your employer? \_\_\_\_\_

#### Referred By:

Doctor  Hospital/Clinic  Patient  Friend/Co-Worker  Family Member  Employer  TV  Internet  Radio  Other

If referred by a Physician: Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

I authorize Austin Sports Medicine to release treatment/account information to the following people: \_\_\_\_\_

#### Medical Insurance Information

\*\* Complete with insured's information \*\*

##### Primary Insurance

Insured's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_

##### Secondary Insurance

Insured's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_

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### 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 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): \_\_\_\_\_

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Chart: \_\_\_\_\_  
Age: \_\_\_\_\_  
Date: \_\_\_\_\_

**AUSTIN SPORTS MEDICINE  
MEDICAL HISTORY**

Today's Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Primary Physician \_\_\_\_\_

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

<b>Yes</b>	<b>No</b>	<b>Details</b>	<b>Medication</b>
<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)**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide details _____

**LATEX ALLERGIES (Check yes or no)**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	If yes, provide details _____

**OTHER MEDICATIONS (current/recent)**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Diuretics
<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinners
<input type="checkbox"/>	<input type="checkbox"/>	Steroids/Cortisone
<input type="checkbox"/>	<input type="checkbox"/>	Weight Control
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Pills
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	Pain Pills
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Anti-inflammatories (e.g. Advil)
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Herbals/Vitamins/Supplements
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

**PREVIOUS SURGERY** (type and dates) \_\_\_\_\_

**PREVIOUS & FUTURE DENTAL PROCEDURES** (type and dates) \_\_\_\_\_

**FAMILY HISTORY** (illness, reactions to anesthesia) \_\_\_\_\_

**RECENT TEST RESULTS** (EKG, check x-ray, blood or HIV tests, etc.) \_\_\_\_\_

**DRINK?** (how often?) \_\_\_\_\_

**SMOKE** (pack/day) \_\_\_\_\_

**WOMEN ONLY**

Pregnant? \_\_\_\_\_

Birth Control (type) \_\_\_\_\_

Date Last Period Started \_\_\_\_\_

<b>For Office Use only</b>	<b>Date / Initials</b>
History Reviewed / Updated	_____
History Reviewed / Updated	_____
History Reviewed / Updated	_____

Name:  
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**AUSTIN SPORTS MEDICINE**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_ **CHART#** \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please circle which applies to you and describe, or check "No problem:"

General: Recent weight changes, fever, weakness, fatigue, headaches

No problem

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Skin: Rashes, eruptions, dryness, jaundice, changes in skin/hair/nails, discoloration, swelling

No problem

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Eyes: Blurred vision, double vision, burning eyes, seeing spots

No problem

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Ears/Nose/Throat: Soreness/redness of gums, hoarseness, difficulty swallowing, head colds, nasal drainage, obstruction, sinus pain, earache, hearing loss, hearing aids

No problem

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Musculoskeletal: Joint pain, swelling, stiffness, deformity

No problem

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Pulmonary: Difficulty breathing, asthma, bronchitis, pneumonia, shortness of breath

No problem

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Neurological: Fainting, blackouts, paralysis, memory loss, dizzy spells

No problem

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Cardiovascular: Chest pain, rheumatic fever, rapid heartbeat, leg swelling, heart valve problems, varicose veins, heart attack

No problem

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Endocrine: Fatigue, hot or cold intolerance, excessive sweating, thirst, hunger

No problem

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Gastrointestinal: Decrease in appetite, nausea, vomiting, diarrhea, constipation, heartburn, hemorrhoids, reflux, blood in stools, ulcers

No problem

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Genitourinary: Urinary frequency/pain, blood in urine, difficulty voiding, incontinence

No problem

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Male: Hernia, testicular problems, penile problems, impotency, infertility

No problem

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Female: Vaginal discharge, pain, discomfort

No problem

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Hematological/Lymphatic: Anemia, easy bruising or bleeding, swollen glands

No problem

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Psychological: Nervousness, mood swings, insomnia, nightmares, depression, irritability

No problem

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Other:

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Name:  
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 Age:  
 Date:

**AUSTIN SPORTS MEDICINE  
 CLINICAL INFORMATION**

What is being examined today? \_\_\_\_\_  Right  Left      Dominant Hand  Right  Left  
 How long have you had this problem? \_\_\_\_\_ Date pain started? \_\_\_\_\_  
 How did the problem first occur? \_\_\_\_\_  
 Have you seen a physician for this problem before?  No  Yes      Doctor \_\_\_\_\_  
 Have you had a previous injury in this area?  No  Yes      If yes, please describe \_\_\_\_\_  
 Have you had surgery on this area? \_\_\_\_\_  
 What physician did your surgery? \_\_\_\_\_  
 Sports/Hobbies \_\_\_\_\_ Level (e.g., High School, Recreational) \_\_\_\_\_  
 What makes your pain better? \_\_\_\_\_  
 What makes your pain worse? \_\_\_\_\_  
 Medications used for this problem: \_\_\_\_\_  
 Do you have Numbness and Tingling? \_\_\_\_\_  
 Do you have swelling? \_\_\_\_\_  
 Have you had any tests for this problem?      MRI / X-Ray / Other: \_\_\_\_\_  
 Does your pain radiate (move)? \_\_\_\_\_  
 Do you have weakness? \_\_\_\_\_

**Pain Drawing:**

Please indicate the locations of your pain with a "X":

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

Describe you pain check all that apply:

- Sharp
- Aching / Throbbing
- Burning
- Comes and goes
- Pins and needles
- Dull
- Constant
- Worse in morning
- Worse at night
- Getting better
- Unchanged
- Getting worse

