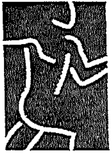


Patient Consent for Care and Treatment

As a patient, you have the right to be informed about your condition and recommended surgical, medical, or diagnostic procedure to be used to decide whether or not to undergo any suggested treatments after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is to obtain your permission to perform necessary evaluation to identify appropriate treatment for any identified condition. Consent will remain effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. We encourage you to ask questions if you have any concerns regarding any test or treatment recommend by your health care provider. You have the right to discontinue services at any time.

I voluntarily request an Austin Sports Medicine physician, physical therapist, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Orthopedic Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Austin Sports Medicine.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

Signature of Patient or Personal Representative Printed Name Date

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).

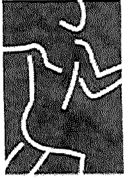
The patient understands that:

- 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): ______________________________



AUSTIN SPORTS MEDICINE

FINANCIAL POLICY

Payment

- The **patient is responsible** for the payment of deductibles, co-insurance, co-pays, and all other treatments not covered by their insurance. We bill according to the negotiated rate with your insurance provider and will collect an estimated amount for the services provided. **Payment is due at the time of service.** We will look to the **adult accompanying a minor** for all services rendered to minor patients. For your convenience we will accept checks and most major credit cards.

Insurance

- The **patient is responsible** for knowing the terms of their insurance. All health plans are not the same and do not cover the same services. It is important you contact your insurance company to verify the following for each time you visit our office:
    - If my provider **is in or out of network**
    - If my insurance will **cover these services**
    - If my insurance requires a **referral** (for example, from my Primary Care Physician)
    - If my insurance requires **Prior authorization**

  ***** If a required referral or authorization is not obtained prior to your visit and you choose to be treated, you will be billed as self-pay. Full payment will be due at the time of service.***
- The **patient is responsible** for providing us with complete and accurate billing information. The patient will be responsible for any charges incurred if the information provided is not correct at the time of service.
- As a courtesy, we will verify your insurance benefits with the information provided prior to services and file a claim for you. You are responsible to respond to any additional requests such as Coordination of Benefits, Subrogation/Accident questionnaires, pre-existing, etc. Depending on your benefits, your insurance may not pay for all of your healthcare cost due to pre-existing condition, exclusion of diagnosis, out-of-network, etc. and you will be financially responsible for all non-covered services.
- If you have questions about your benefits coverage, please contact your insurance directly.
- The **patient is responsible** for any amount not covered by your insurer. Many insurance companies have additional stipulations that may affect your coverage. If your insurance denies any part of your claim, or if you or your physician elects to continue treatment past your approved period, you will be responsible for your account balance in full.
- In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Instances of the insurance carrier not covering services include but are not limited to: absence of referral or authorization, determination of non-medical necessity, procedure is deemed experimental, your provider is out of network, inactive coverage, exhaustion of contracted benefits, and concurrent services from multiple providers.
- If your insurance company fails to pay your bill or you have a remaining balance due, you will receive a statement. Payment is due on receipt.
- If you have a balance on your account, you will receive a total of three (3) statements. Should your account become more than 90 days past due, your account will be sent to a collection agency.
- If we cannot verify your benefits prior to your scheduled appointment time, a deposit equal to the self-pay amount will be due at the time of service. If we later receive a payment from your insurer, we will refund you for any overpayment.

Self-Pay Disclosure

- MD Office Visit: $400 (MD consult including X-Ray)
- PT Evaluation- $250
- PT Re-evaluation- $200
- PT Follow-up Visit- $150
- Dry Needle: $50 per unit (8-15 minutes = 1 unit)

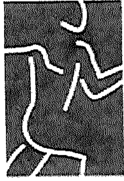
Additional Fee Disclosures

- **Clinic No-Show fee** = $50.00 for each scheduled office visit
- **Clinic Cancellation fee** = $25.00 for office visit appointments not cancelled **24 hours in advance**

  ***Monday appointments** must be **cancelled by 4pm the Friday before** to avoid a cancellation charge.

  *As a courtesy to all our patients, appointments will be rescheduled if you are more than fifteen (15) minutes late.

  **3 No Shows or late cancels may warrant the discharge of the patient from further treatment at ASM. A referral to another therapy provider may be provided on request.
- Surgical No-Show/Cancellation Fee = $250 (cancellation of any surgical procedures requires at least 24-hour notice).



AUSTIN
SPORTS
MEDICINE

FINANCIAL POLICY

Credit Card Authorization

- For ease of payment during your visit, you may elect to keep your credit card stored on file with us.

By my signature below, I authorize Austin Sports Medicine to save my card on file upon checkout for future payments. Payments will not be processed without the authorization and consent of the responsible party.

Signature: ______________________________ **Date:** ____________________

Medical Records Requests

- All records requests require a signed Medical Release Form. Please allow up to 10 business days for all records requests to be processed.
    - Medical Records <10 pages = no charge
    - Medical Records > 10 pages = $25
    - Billing Records (flat rate fee) = $25
    - FMLA Paperwork (filled out by office) = $25
- All other requests for records will be billed according to the Texas Administrate Code Title 22 Part 9 Chapter 165 Rule 165.2, which states: No more than $25 for the first 20 pages; then, $0.50 per page for every copy thereafter, actual cost of mailing of shipping and a reasonable fee not to exceed $15 for executing an affidavit. Charge for x-ray/diagnostic imaging is $8 per copy of an imaging study.

Workers Compensation/Motor Vehicle Accident

- If your injury is due to a **motor vehicle accident**, services provided for MVA will be filled to your health insurance carrier. However, if your carrier does not cover treatment, you will be responsible for payment. We do not accept Letters of Protection, nor do we file under motor vehicle insurance.
- 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 initial the applicable statement:

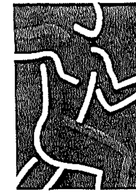
_____ I certify that my injury/condition <u>IS work related.</u> _____ I certify that my injury/condition <u>IS NOT work related.</u>

By my signature below, I certify that I have read, understand and agree to be bound by the statements and terms in this Financial Policy document.

Patient Name (Printed): ____

Signature: ______________________________ **Date:** ____________________

Name: ______________________
DOB: ______________________
Chart: ______________________
Age: ______________________
Date: ______________________



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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. ____________ Approx 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 ____________

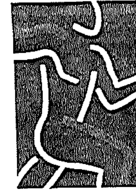
Emergency Contact: ____________ Relationship to the patient: ____________
I authorize Austin Sports Medicine to release treatment/account information to the following people: ____________

MEDICAL INSURANCE INFORMATION

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

Primary	Secondary
Primary Insurance ____________	Secondary Insurance ____________
Insured's Name ____________	Insured's Name ____________
Date of Birth ____________	Date of Birth ____________
Social Security # ____________	Social Security # ____________
Relationship to Patient ____________	Relationship to Patient ____________
Claims Address ____________	Claims Address ____________
City ____________ State ______ Zip ______	City ____________ State ______ Zip ______
ID# ____________ Group # ____________	ID# ____________ Group # ____________
Employer ____________	Employer ____________

Name: ______________________
DOB: ______________________
Chart: ______________________
Age: ______________________
Date: ______________________



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MEDICAL HISTORY

Today's Date ______________ Age ______________ Height ______________ Weight ______________

Primary Physician ______________________________

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

Yes	No	Details	Medication
☐	☐	High Blood Pressure ______	______
☐	☐	Heart Problems/Pacemaker/Chest Pain ______	______
☐	☐	Diabetes ______	______
☐	☐	Cancer ______	______
☐	☐	Asthma/Lung Disease/Shortness of Breath ______	______
☐	☐	Hepatitis/Liver Disorders ______	______
☐	☐	Thyroid Problems ______	______
☐	☐	Bleeding Problems/Stroke ______	______
☐	☐	Blood Clots/Phlebitis ______	______
☐	☐	Kidney Disease ______	______
☐	☐	Frequent Bladder Infections ______	______
☐	☐	Stomach Ulcer/Bleeding ______	______
☐	☐	Depression/Mental Illness ______	______
☐	☐	Recent Weight Change ______	______
☐	☐	Eyes, Vision Change ______	______
☐	☐	Ear, Nose, Throat, Mouth Problems ______	______
☐	☐	Seizure ______	______
☐	☐	Osteoporosis ______	______
☐	☐	Numbness/Tingling ______	______
☐	☐	Other Illness/Hospitalization ______	______
☐	☐	Previous Bone or Joint Problems ______	______
☐	☐	Other Sports Injury ______	______

☐ ☐ **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 ______________

DRUG ALLERGIES (Check yes or no)

Yes	No	
☐	☐	If yes, provide details ______________

LATEX ALLERGIES (Check yes or no)

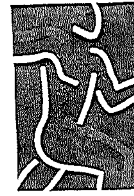
Yes	No	
☐	☐	If yes, provide details ______________

OTHER MEDICATIONS (current/recent)

Yes	No	
☐	☐	Diuretics
☐	☐	Blood Thinners
☐	☐	Steroids/Cortisone
☐	☐	Weight Control
☐	☐	Sleeping Pills
☐	☐	Antibiotics
☐	☐	Pain Pills
☐	☐	Aspirin
☐	☐	Anti-inflammatories (e.g. Advil)
☐	☐	Herbals/Vitamins/Supplements
☐	☐	Other

For Office Use only	*Date / Initials*
History Reviewed / Updated	______________
History Reviewed / Updated	______________
History Reviewed / Updated	______________

Name: ____________________
DOB: ____________________
Chart: ____________________
Age: ____________________
Date: ____________________



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REVIEW OF SYSTEMS

NAME ____________________ DATE ____________ CHART# ____________

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

General:
☐ No problem
☐ Fever ☐ Weakness ☐ Fatigue ☐ Headaches
☐ Recent weight changes

Skin:
☐ No problem
☐ Rashes ☐ Eruptions ☐ Dryness ☐ Jaundice
☐ Swelling ☐ Discoloration ☐ Changes in skin/hair/nails

Eyes:
☐ No problem
☐ Double vision ☐ Burning eyes ☐ Seeing spots

Ears/Nose/Throat:
☐ No problem
☐ Hoarseness ☐ Head colds ☐ Obstruction ☐ Nasal drainage
☐ Sinus pain ☐ Earache ☐ Hearing loss ☐ Hearing aids
☐ Difficulty swallowing ☐ Soreness/redness of gums

Musculoskeletal:
☐ No problem
☐ Joint pain ☐ Swelling ☐ Stiffness ☐ Deformity

Pulmonary:
☐ No problem
☐ Asthma ☐ Bronchitis ☐ Pneumonia
☐ Shortness of breath ☐ Difficulty breathing

Neurological:
☐ No problem
☐ Fainting ☐ Blackouts ☐ Paralysis ☐ Memory loss
☐ Dizzy spells

Cardiovascular:
☐ No problem
☐ Chest pain ☐ Leg swelling ☐ Varicose veins ☐ Heart attack
☐ Rapid heartbeat ☐ Rheumatic fever ☐ Heart valve problems

Endocrine:
☐ No problem
☐ Fatigue ☐ Hot or cold intolerance ☐ Excessive sweating, thirst, hunger

Gastrointestinal:
☐ No problem
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Heartburn ☐ Hemorrhoids ☐ Reflux ☐ Blood in stools
☐ Ulcers ☐ Decrease in appetite

Genitourinary:
☐ No problem
☐ Incontinence ☐ Blood in urine ☐ Urinary frequency/pain
☐ Difficulty voiding

Male:
☐ No problem
☐ Hernia ☐ Impotency ☐ Infertility ☐ Penile problems
☐ Testicular problems

Female:
☐ No problem
☐ Pain ☐ Discomfort ☐ Vaginal discharge

Hematological/Lymphatic:
☐ No problem
☐ Anemia ☐ Swollen glands ☐ Easy bruising or bleeding

Psychological:
☐ No problem
☐ Nervousness ☐ Mood swings ☐ Insomnia ☐ Nightmares
☐ Depression ☐ Irritability

Other:

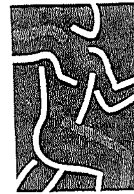
Name: ______________________

DOB: ______________________

Chart: ______________________

Age: ______________________

Date: ______________________



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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? ______________

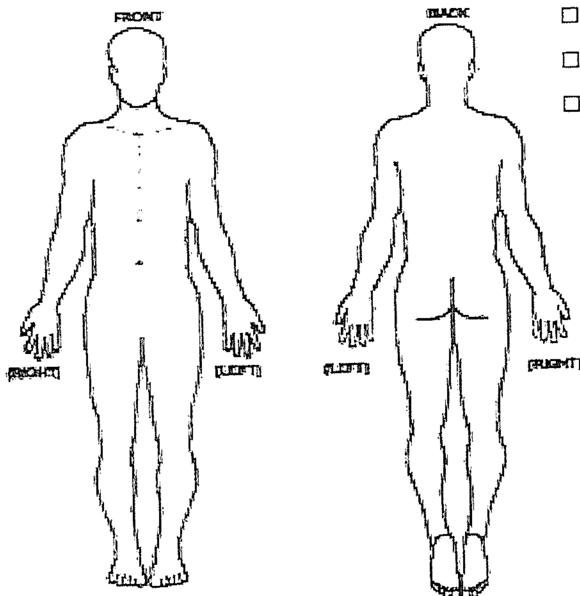
Have you had any tests for this problem? ☐ MRI ☐ X-Ray ☐ Other: ______________

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 ☐ Pins and needles ☐ Worse at night

☐ Aching / Throbbing ☐ Dull ☐ Getting better

☐ Burning ☐ Constant ☐ Unchanged

☐ Comes and goes ☐ Worse in morning ☐ Getting worse