SPORTS MEDICINE ASSOCIATES

MR# _____
Office Use Only

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	ADDRESS	
CITY	STATE	ZIP	CELL PHONE	HOME PHONE
DATE OF BIRTH	MARITAL STATUS	SEX	SOCIAL SECURITY NUMBER	TDL#
	☐ S ☐ M ☐ D ☐ W	☐ MALE ☐ FEMALE		
EMAIL ADDRESS	EMPLOYER			
ADDRESS OF EMPLOYER	OCCUPATION	BUS. PHONE		

SPOUSE OR PARENT INFORMATION

LAST	FIRST	MI	RELATIONSHIP	ADDRESS		PHONE
EMPLOYER & ADDRESS				DOB	BUS. PHONE (A/C &NO.)	SOCIAL SECURITY NUMBER
EMERGENCY CONTACT			RELATIONSHIP	ADDRESS		PHONE

INSURANCE GUARANTOR INFORMATION

LAST	FIRST	MI	RELATIONSHIP	ADDRESS		PHONE
EMPLOYER & ADDRESS				DOB	BUS. PHONE (A/C &NO.)	SOCIAL SECURITY NUMBER

RACE

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER RACE ☐ REFUSED ☐ UNKNOWN

ETHNICITY

☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNKNOWN ☐ REFUSED

PREFERRED LANGUAGE _____

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE				ADDRESS OF PRIMARY INSURANCE COMPANY		
INSURED'S NAME	DOB	IF GROUP INSURANCE, NAME OF EMPLOYER		GROUP NO.		ID NO.
SECONDARY INSURANCE COVERAGE				ADDRESS OF SECONDARY INSURANCE COMPANY		
INSURED'S NAME	DOB	IF GROUP INSRUANCE, NAME OF EMPLOYER		GROUP NO.		ID NO.
CO-PAY	HMO	PPO	MEDICARE NUMBER		MEDICAID NUMBER	

Payment is expected at the time services are rendered unless prior arrangements have been made.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

I hereby authorize payment directly to Sports Medicine Associates of San Antonio for medical services rendered I authorize the release of my medical information deemed necessary in the processing of a claim. It is my understanding that I am responsible for this amount, regardless of insurance coverage.

_____ _____

SIGNATURE **DATE**

MR# _____

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SPORTS MEDICINE ASSOCIATES

OFFICE POLICIES

Sports Medicine Associates of San Antonio, PA would like to welcome you to our office. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be given for your records upon request.

1. **PAYMENTS**. All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. We accept Visa, MasterCard or American Express.
2. **CANCELLATIONS.** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment.
3. **APPOINTMENT TIME.** We ask that our patients arrive on time for their appointments; this will facilitate our ability to see you as scheduled. New patients are asked to arrive 15-20 min early to fill out initial paperwork. In an effort to serve all our patients well, patients arriving past their appointment time may be rescheduled. Occasionally we encounter medical emergencies or unforeseen circumstances that require immediate attention. On these occasions we may run late.
4. **HMO & PPO REFERRALS**. If your policy requires written authorization from your Primary Care Physicians, we will request authorization, in advance, for established patients only. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION**. Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a new Patient Information Form and may not be changed over the telephone.
6. **YOUR ATTENDING PHYSICIAN**. Once you have selected a physician, he will be your Attending Physician throughout your treatment at our office. If, during the course of your initial treatment your physician is unavailable, another physician may treat you in his/her absence. You will return to the care of your Attending Physician upon his/her return.
7. **MEDICATION REFILL REQUESTS.** Please contact your pharmacy first. They will call our office for authorization of the refill.
8. **AFTER HOUR CARE**. In an emergency, please dial the main office number at 210.699.8326 and leave a message with the answering service, the physician on-call will return your phone call as soon as possible. In a life threatening emergency, dial 911.
9. **MEDICAL RECORDS.** Sports Medicine Associates of San Antonio outsources our release of information process to HealthMark Group.
    - To submit a request visit https://requestmanager.healthmark-group.com
    - First time users are required to register for an account before accessing their website. Once logged in, you may select Submit Request from the menu options and enter all required fields to submit an authorization to HealthMark Group directly . They will process your medical record request and one completed you will receive a notification via mail or email.
    - The total process time of requests is approximately seven days. To follow up on the status of your request you may contact HealthMark Group directly Monday - Friday, 8 a.m. - 5 p.m. CST at 800-659-4035 or status@healthmark-group.com. For status on your FMLA you may contact them at fmla@healthmark-group.com
10. **COMPLETION OF FORMS**. As per the rules adopted by the Texas State Board of Medical Examiners, requests for the completion of medical forms can be submitted to HealthMark Group by visiting https://requestmanager.healthmark-group.com.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

SIGNATURE _____ **DATE** _____

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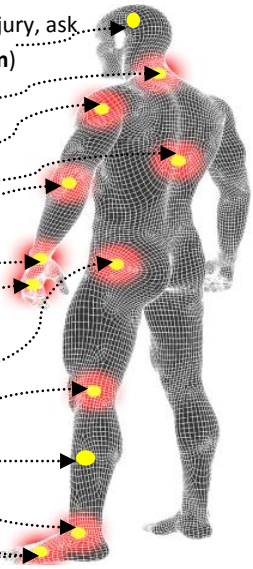
HISTORY & PHYSICAL FORM

Patient _____ **DOB** _____ **Age** _____

Side: ☐ Left ☐ Right

Which body part is **most affected?**

☐ Head (if head injury, ask for **Concussion Form**)
☐ Neck
☐ Shoulder
☐ Back
☐ Elbow
☐ Wrist
☐ Fingers/ Hand
☐ Buttock
☐ Knee
☐ Lower leg
☐ Ankle
☐ Foot
☐ Toes



Pain Level

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Frequency
☐ Constant
☐ Intermittent (comes & goes)
☐ w/ Activity

Duration (how long does it last)
☐ 5-30 min
☐ 30- 1 hour
☐ > 1 hour

Radiation (does pain travel)
☐ Yes
☐ No

If yes, where? _____

Which doctor are you seeing today?

☐

Referred by _____

Height _____ **Weight** _____

Hand Dominance:

☐ Right ☐ Left ☐ Ambidextrous

How long have you had the pain? _____ **Is the pain resulting from an injury?** ☐ Yes ☐ No

If yes, how: ☐ Sports Injury *(which sport)* _____ School _____

☐ Fall ☐ Car Accident ☐ Overuse ☐ Work ☐ Other

Date ____/____/_____ How did it happen? _____

_____

Circle **ALL** that best describe your pain

Quality: ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing ☐ Shooting

What Makes it Worse: ☐ Bending ☐ Climbing Stairs ☐ Descending Stairs ☐ Lifting ☐ Pushing ☐ Sitting ☐ Standing ☐ Walking

What Makes it Better : ☐ Brace/Splint ☐ Elevation ☐ Exercise ☐ Ice ☐ Heat ☐ Injections ☐ Massage ☐ Medication ☐ Mobility ☐ Physical Therapy ☐ Rest ☐ Stretching

Symptoms: ☐ Bruising ☐ Crackling/Grating ☐ Decreased Mobility ☐ Weakness ☐ Instability ☐ Difficulty going to sleep ☐ Night Time Awakening ☐ Limping ☐ Locking ☐ Numbness ☐ Popping ☐ Weakness ☐ Tightness ☐ Spasms ☐ Tenderness

Have you been treated previously by another provider for this body part? ☐ Yes ☐ No

* If yes, please bring any X-rays, MRI Films, or any other Medical Records that may be pertinent to this visit *

Any previous problems or injuries? ☐ Yes ☐ No If yes, please describe: _____

Check ANY previous treatments and/or testing for this injury?

☐ X-Rays ☐ CT Scans ☐ MRI ☐ Physical Therapy ☐ Injections ☐ Surgery ☐ Medications ☐ Chiropractor

_____ _____

SIGNATURE **Date**

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HISTORY & PHYSICAL FORM (continued)

Patient _____ **DOB** _____

MEDICATIONS Preferred Pharmacy :_____ ☐ **NONE / NO CHANGE**

Medication	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES (Please list ALL allergies including contrast dyes, metal, latex, medication or other) ☐ **NONE**

Name	Name

PERSONAL MEDICAL HISTORY (Please check if YOU currently have or had the following diseases/conditions)

☐ Anemia/Bleeding Disorder
☐ Antibiotic Resistant Infection/MRSA
☐ Arthritis
☐ Asthma/COPD/Emphysema Breathing Problems
☐ Blood Clots
☐ Cancer
☐ Carpal Tunnel Syndrome
☐ Diabetes
☐ GOUT
☐ High Blood Pressure
☐ Heart Problems/Heart Attack/ Stents
☐ HIV / Hepatitis A/B/C
☐ Kidney Disease
☐ Osteoporosis
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Other:_____
_____
_____
_____
_____
_____

PREVIOUS SURGERIES (Please list ALL previous surgeries and dates) ☐ **NONE**

Procedure/Date	Procedure/Date
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Yes Packs Per Day: _____ If quit, when? _____
Do you drink alcohol? ☐ No ☐ Yes Type: _____ How Much/Often? _____
Recreational Drug Use? ☐ No ☐ Yes Type: _____(including marijuana)

The above information is true and correct to the best of my knowledge.

_____ _____
SIGNATURE **DATE**

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Notice of Privacy Practices – Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____

Print

Consent for Physician Care/Treatment and Obtain Medication History

I, **(Patient's printed name)**_____ hereby agree and give my consent for *Sports Medicine Associates of San Antonio,PA*, to provide physician services and obtain medication history considered necessary and proper for the assessment, diagnosis, and treatment of my physical condition. Treatment plan will be reviewed with me prior to implementation.

_____ _____

Patient or legally authorized individual signature Date

_____

Print

Consent for Medical Release of Information

May we have standing permission to discuss your health issues with one or more family members?
You do not need to allow us to speak to anyone but realize if your family member or caregiver calls in for any reason, they will not be able to receive information unless written permission is given:

Sports Medicine Associates of San Antonio, PA may share information with:

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

_____ _____

Patient or legally authorized individual signature Date

(You may revoke these permissions at any time and to the extent information has not already been shared we will comply.)

This form will be retained in your medical record.

SPORTS MEDICINE ASSOCIATES
Any Athlete. Any Injury. Anytime.®

Patient Consent for Photography/Authorization for Publication

Patient name: _____ DOB: _____

Address: _____

City, State, ZIP: _____ Phone: _____

I hereby give my consent to Sports Medicine Associates of San Antonio and its affiliates and agents to take photographs or produce videotapes, audiotapes, electronic files, or other types of media productions that capture my name, voice and/or image, to be used by Sports Medicine Associates of San Antonio for the purpose of:

- Publications and/or promotional materials
- Closed circuit television programs
- Websites and social media
- News Media (online, print and/or broadcast)
- Advertisements
- Other: _____

The information to be disclosed includes (check all that apply):

☐ Photographs, videotaped images, or other images
☐ Audio recordings of me and/or my voice
☐ Testimonials
☐ Interview me and take written notes
☐ Use Health information

The above has been explained to me and I understand the photographs, audiotapes, videotapes or interviews taken for marketing or publicity purposes may be used for publications and/or broadcast by the media, for public affairs purposes, including publications, advertisements, displays and/or placement on the Sports Medicine Associates of San Antonio website. I hereby waive all rights that I may to any claims for payment or royalties in connection with the use of these photographs, audiotapes, videotapes and interviews and agree that these shall at all times be the property of Sports Medicine Associates of San Antonio.

I understand that all photographs, audiotapes, videotapes or interviews taken for purposes of education and/or performance improvement will be protected health information ("PHI") and will be maintained in a protected and secure manner with access restricted to the minimum necessary to carry out the aforesaid functions. I may receive copies of any such PHI upon request and a reasonable fee may be charged for any associated costs.

I understand that any personal health information or other information released may be subject to re-disclosure and may no longer be protected by applicable federal and state privacy laws. I further understand that this authorization is voluntary, without compensation, and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or receive payment from my insurance company. It will also not affect my eligibility for benefits.

I understand that this consent is subject to revocation/withdrawal by me at any time in writing to: Sports Medicine Associates of San Antonio, 21 Spurs Lane Suite 300, San Antonio, Texas 78240. except to the extent that action has already been taken to release this information. I have a right to receive a copy of this authorization.

I hereby release Sports Medicine Associates of San Antonio or any of its affiliates, employees, or agents from all liability, including any claims for libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from, the taking and authorized use of these photographs, audiotapes, videotapes, and interviews.

_____ _____

Signature of Patient/Legal Representative Date

_____

Printed name and Relationship to the patient

For Sports Medicine Associates of San Antonio purposes only:

Purpose: _____

_____ _____

Signature of Sports Medicine Associates of San Antonio representative Date