SMI
SPORTS MEDICINE INSTITUTE

FIRST VISIT DATE: _____ **APPT TIME**: _____

PATIENT TYPE: W/C PRVT MC CASH

THERAPIST: JOAN BOESEL ASHLEY ROJAN

PLEASE WRITE LEGIBLY

PATIENT INFORMATION

LAST NAME _____ FIRST _____ M.I._____ Mr. / Mrs. / Ms.

MY PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS? Please circle: E-MAIL TEXT BOTH NEITHER

E-MAIL _____

BEST PHONE # TO REACH YOU _____ OTHER PHONE_____

ADDRESS_____CITY _____ STATE_____ZIP_____

SSN_____ DATE OF BIRTH _____ AGE _____ GENDER: M / F

DRIVERS LICENSE _____ PLEASE CIRCLE MARITAL STATUS: Married Single Divorced Separated

WHO DOES SMI HAVE PERMISSION TO DISCUSS YOUR CARE WITH? _____

EMERGENCY CONTACT INFORMATION (PARENT/GUARDIAN INFORMATION IF PATIENT IS A MINOR)

LAST NAME_____FIRST _____RELATIONSHIP_____

E-MAIL _____

BEST PHONE # TO REACH YOU _____OTHER PHONE_____

ADDRESS_____CITY_____STATE_____ ZIP_____

EMPLOYMENT INFORMATION

EMPLOYMENT: ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED ☐ STUDENT

OCCUPATION _____EMPLOYER _____

EMPLOYER ADDRESS_____

CITY_____STATE_____ ZIP_____ TELEPHONE_____

PHYSICIAN INFORMATION

REFERRING MD LAST NAME_____FIRST_____

TELEPHONE _____

ADDRESS_____CITY _____ STATE_____ ZIP_____

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INJURY TYPE

REASON FOR THERAPY _____ INJURY DATE _____

□ WORK □ AUTO □ HOME □ STUDENT ATHLETE □ OTHER_____ SURGERY DATE _____

IS THIS A WORKERS COMPENSATION INJURY? □ Y □ N IF YES, CLAIM NUMBER _____

ADJUSTOR NAME _____ PHONE _____ FAX _____

IS AN ATTORNEY INVOLVED? □ Y □ N IF YES, ATTORNEY NAME/PHONE_____

PRIMARY INSURANCE COMPANY

PRIMARY INSURANCE COMPANY _____ PHONE _____

NAME OF POLICY HOLDER_____GROUP # _____

DATE OF BIRTH OF POLICY HOLDER _____ INSURANCE ID/ SS # _____

SECONDARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY_____ PHONE _____

NAME OF POLICY HOLDER_____ GROUP # _____

DATE OF BIRTH OF POLICY HOLDER _____ INSURANCE ID/ SS # _____

NOTE: IN THE EVENT YOU HAVE A BALANCE OWED SMI, YOU WILL RECEIVE YOUR STATEMENT VIA E-MAIL. PLEASE **PROVIDE THE E-MAIL ADDRESS OF THE PERSON RESPONSIBLE FOR YOUR ACCOUNT**: _____
IF YOU DO NOT HAVE AN EMAIL ADDRESS, WE WILL SEND YOU PAPER STATEMENTS TO THE ADDRESS SPECIFIED.

ASSIGNMENT OF INSURANCE BENEFITS

- CO-PAY, CO-INSURANCE, AND/OR DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF TREATMENT. IF YOU ARE UNABLE TO SETTLE YOUR ACCOUNT AT THE TIME OF EACH OFFICE VISIT, SPECIAL ARRANGEMENTS MUST BE MADE IN ADVANCE WITH OUR OFFICE.
- PATIENTS WHO HAVE MEDICAL INSURANCE SHOULD UNDERSTAND THAT CHARGES FOR PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT AND NOT TO THE INSURANCE COMPANY. PAYMENT FOR CHARGES INCURRED IS THE RESPONSIBILITY OF THE PATIENT OR THE PARENT/GUARDIAN OF PATIENT IF A MINOR.
- OUR OFFICE WILL BILL YOUR INSURANCE CARRIER AS A COURTESY; HOWEVER, WE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING FROM YOUR INSURANCE CARRIER IF THEY DO NOT PAY, OR FOR NEGOTIATING A DISPUTED CLAIM. I HEREBY AUTHORIZE SPORTS MEDICINE INSTITUTE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS TREATMENT AND I HEREBY ASSIGN ALL PAYMENT FOR SERVICES RENDERED TO SMI.

PRINTED NAME _____

SIGNED _____ **DATE** _____

MESSAGE FROM SPORTS MEDICINE INSTITUTE
HEALTH INFORMATION PRIVACY NOTICE
EFFECTIVE MAY 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. ABOUT PROTECTED HEALTH INFORMATION "PHI"

In this notice "we," "our" or "us" refers to Sports Medicine Institute (SMI) and our workforce of employees and volunteers. "You" and "your" refers to each of our patients who are entitled to a copy of the notice. We will use good faith regarding protecting your privacy; however, it is no guarantee from any and all potential risks.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect health information about you in the manner that we describe here. Certain types of health information may specifically identify you. Because we must protect this health information, we refer to it as PHI. In this notice we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or with a complaint

2. SOME OF THE WAYS WE USE OR DISCLOSE YOUR PHI

We will use your PHI to treat you. We will use your and/or disclose your PHI in order to get paid for your care. We are allowed to use or disclose your PHI for certain activities that we call "health care operations." Health care operations involve the administration and quality assurance activities in our facility. We will give you examples of each of these to help explain them. However, this is not a complete list of all uses or disclosures.

- TREATMENT: We use and disclose your PHI in the course of your treatment. For example, if you are in our clinic and one of our employees has a question about your condition, we may communicate with your treating physician regarding your diagnosis and plan of care so that we can provide the optimal course of treatment for you. We may also use or disclose your PHI for other related types of treatment activities.
- MARKETING: It will be necessary for us to communicate with your referring physician regarding your evaluation and progress in physical therapy. This may include an introductory letter from our clinic, informing your physician that we are treating you for your injury/injuries, as well as who your therapist is in case your physician needs to contact him/her regarding your therapy. This may also include evaluations, progress notes, etc. This allows us to keep a direct line of communication with your physician about your progress and plan of care. **PHI is not disclosed to any entity that is not directly related to your treatment (for example: advertising agencies, magazines, publications, etc.).**
- PAYMENT: After we treat you, we will ask your insurer to pay us. We use a billing company to administer our billing. We will provide your medical information to SMI Billing so they can provide the required information to your insurance company. SMI and/or SMI Billing use your PHI to tell your insurer what type of health problem you had and what we did to treat you. Your insurer may ask SMI and/or SMI Billing to give them your membership number in your employer's health plan, or your insurer may want to review your medical records to be sure that your care was necessary.
- SPECIAL USES: We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to remind you that you have an appointment with us for treatment or to contact you if you have a payment due or a balance on your account.
- YOUR AUTHORIZATION MAY BE REQUIRED: In many cases summarized here, we may use or disclose your PHI either with your consent or as required or permitted by law. In all other cases, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you later change your mind, you may revoke your authorization.

3. CERTAIN USES AND DISCLOSURES OF YOUR PH THAT ARE REQUIRED AND PERMITTED BY LAW

Many laws and regulations apply to us that affect your PHI. These laws and regulations may either require us or permit us to use of disclose your PHI. From the federal health information privacy regulations, here is a list describing required or permitted uses and disclosures.

- If you do not verbally object, we may share some of your PHI with a family member or friend who is involved in your care.
- We may use your PHI in an emergency when you are not able to express yourself.
- When required by law; for example, when ordered by a court to turn over certain types of your PHI we must do so.
- For public health activities such as reporting a communicable disease or reporting an adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- In judicial or administrative proceedings such as in response to a valid subpoena.
- When properly requested by law enforcement officials (such as reporting gunshot wounds), or for other legal requirements.
- If we reasonably believe that to do so will avert a health hazard or to respond to a threat to public safety such as an imminent crime against another person.
- If you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- If you have a valid Workers Compensation claim and the carrier requires various PHI.

4. CERTAIN STRICTER REQUIREMENTS THAT WE FOLLOW
Several state laws may apply to your PHI that set a stricter standard than the protections required by the federal health privacy regulations.

5. YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM
You have specific rights under our federally required privacy program, each summarized here.

- Your right to request limited use or disclosure: You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do not agree to your request, we must abide by the agreement.
- Your right to confidential communication: You have the right to receive confidential communications from us at a location that you provide. We require that you make your request in writing, provide us with the other address and explain to us if the request will interfere with your method of payment for your care.
- Your right to revoke your consent and authorization: If you have granted us your consent or authorization to use or disclose your PHI, you may revoke the consent or authorization in writing. However, if we have relied on your consent or authorization, we may use or disclose your PHI to that extent.
- Your right to inspect and copy: You have the right to inspect and copy your PHI. We may refuse to give you access to your PHI if we think it may cause your harm but we have to explain why and give you someone to contact about our decision who will explain how and when to get a review of our refusal.
- Your rights to amend your PHI: If you disagree with what your PHI in our records say about you, you have the right to request in writing that we amend your PHI when it is in a record that we create or have maintained for us. We are not required to respond to your request if the records you are asking about are not our records. We may refuse to make your requested amendment. Then, you will have a right to submit a written statement about why you disagree. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.
- Your right to know who else sees your PHI: You have the right to request an accounting of certain disclosures that we have made of your PHI over the past 6 years. We do not have to account for all disclosures, including those involving treatment, payment and health care operations as described above. There is no charge for an annual accounting but there may be for additional accountings. We will tell you if there is a charge for your accounting and you will have the right to withdraw your request, or to pay to proceed.
- Your right to complain: If you believe that your privacy rights have been violated, you have the right to make a complaint to us, or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint, you should submit in writing to the contact person identified in this notice (7, below). Your complaint should provide a reasonable amount of specific detail to enable us to investigate a potential problem.

6. SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE PERFORM THEM
We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you notice of our privacy practices. This document is our notice. If you did not get a paper copy of this notice, you may have one. We will abide by the privacy practices set forth in this notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

7. CONTACT INFORMATION
If you have question about this notice, or if you have a complaint, please contact:

Sports Medicine Institute
Attn: Joan Boesel
1940 N. Glassell St.
Orange, CA 92865
(714) 939-6200

8. EFFECTIVE DATE
This notice takes effect on May 1, 2013

FINANCIAL POLICY STATEMENT

Please help us make your treatment as effective and consistent as possible. An updated prescription is required in order for your insurance company to be responsible for physical therapy treatment. Insurance companies will not pay for treatment sessions beyond the prescribed time limit from the initial prescription. **Please note that your prescription begins on the date it was written by your MD.**

As a courtesy to our patients, we bill insurance claims with a maximum of two insurance carriers. If you fail to provide us with your secondary insurance before treatment begins, we will NOT bill your secondary insurance retroactively for you. You will be responsible for the remainder of the bill. **Your insurance is a contract between you and your insurance carrier, and you are ultimately responsible for the verification of your insurance benefits and limitations.** Filing insurance claims is not a guarantee of payment. If your insurance carrier has not paid us within 45 business days, we will bill you directly for the services rendered. We require full payment at the time services are rendered if: 1) you do not have insurance, 2) you are unable to provide proof of coverage at the time of service, 3) your insurance carrier is not contracted with us (i.e. out of network coverage), and 4) you have not met your deductible for the year.

All monies owed by the patient (co-payment, co-insurance, deductible, required "out of pocket" amounts, etc.) are due at the time services are rendered. **We require that arrangements for payment of your estimated share be made today and each time you come in for physical therapy.** You are responsible for any refund requested of us by your insurance company for payments they have made to us. It is your responsibility to pay any charges that are deemed not a covered service, not authorized, not a covered benefit, or not medically necessary by your insurance. You are responsible for any charges incurred once your physical therapy benefits have been exhausted and any charges that your insurance company has determined as not medically necessary. Any patient who is treated at the Sports Medicine Institute without proper authorization from their insurance is responsible for the full charge of the services rendered if no payment is authorized retroactively. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Sports Medicine Institute.

Should you decide not to provide us with your insurance information for any reason and begin physical therapy treatment on a cash pay basis, full payment is due at the time services are rendered, and SMI will not retroactively bill your insurance.

The above financial policy does not apply to patients covered by Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

In the event of any default, Sports Medicine Institute may declare the entire unpaid balance to be immediately due and payable, and if Sports Medicine Institute then assigns this agreement to a collection agency for recovery, the patient will also be responsible for up to 30% of the unpaid principle balance as the reasonable cost of collection.

For your convenience, we accept Visa, MasterCard, American Express, checks and cash. There will be a $25 charge for each check that is returned for insufficient funds.

NO SHOW/LATE CANCELLATION POLICY

In an effort to be as available as possible to our patients we require 24 hours' notice for cancelling an appointment. If 24 hours' notice is not given, SMI is unable to make that appointment available to another patient. In an effort to recover lost revenue, you will be charged a $50.00 fee for any missed appointment without required notification. This charge is your responsibility and payment is required before subsequent appointments will be honored. Your insurance company will not be billed for that day. Please note that if you fail to keep two consecutive appointments and have not called to reschedule, your subsequent appointments will be cancelled, and another appointment will not be scheduled until the outstanding charges have been paid.

_____Initial
_____Date

POLICIES AND PROCEDURES

1. **Consent for Care and Treatment**: I, the undersigned, do hereby give my consent for Sports Medicine Institute to furnish Physical Therapy services considered necessary in evaluating and treating my physical and mental condition. This authorization is given voluntarily and I acknowledge that no guarantees have been made to me as to the results of the treatments.

_____Initial

2. **Financial Policy Statement**: I, the undersigned, have received a copy of and read the SMI Financial Policy Statement. I understand my responsibility for the payment of my account.

_____Initial

3. **Authorization for Release of Information:** Sports Medicine Institute may release information from my medical record to any health care provider involved in my care and treatment. SMI may also release information from my medical record to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, SMI is no longer responsible for the confidentiality of any information known or possessed by the payer.

_____Initial

4. **Charge for No Show/Cancellation without 24 hour notice:** I, the undersigned, have received a copy of and read the SMI No show/cancellation policy and understand that 24 hour notice is required for cancelling an appointment, and that I will be charged a $50.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day. If I fail to keep two consecutive appointments, another appointment will not be scheduled until I have paid any outstanding charges.

_____Initial

5. **Health information Privacy Notice:** I acknowledge that SMI has supplied me with a copy of their health information privacy notice regarding their policies and procedures concerning my protected health information.

_____Initial

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient or person authorized either by the patient or otherwise to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payments due at the time of service.**
- **I have received a copy of the SMI No Show/Late Cancellation and Financial Policies and understand my responsibility with respect to paying my account.**
- **I have received a copy of the SMI HIPAA Policy.**

_____

Patient/Guardian/Responsible Party (Print Name) Date

_____

Patient/Guardian/Responsible Party (Signature)

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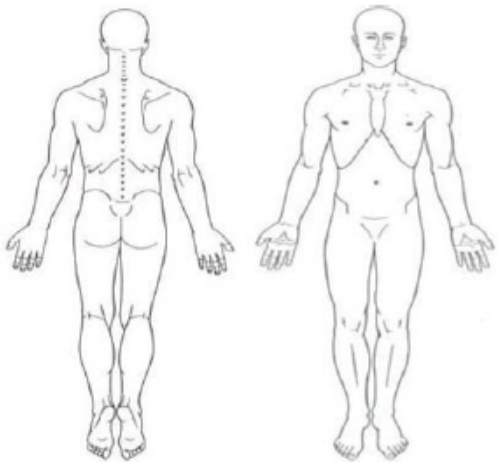
MEDICAL HISTORY
(Mark pain on diagram)



Name _____

Date of Injury/Onset _____

Describe injury or onset of condition _____

Have you had previous treatment for this condition?_____

Surgical Procedure & Date _____

Are you currently experiencing or have you ever experienced any of the following?

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/ Low Blood Pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/ AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Have you had any of the following tests?: ☐X-Rays ☐MRI ☐CT Scan ☐EMG ☐Other _____

If yes on any of the above please explain & give approximate dates _____

_____

Type of pain: sharp / burning / aching / tingling / numbness / other _____

Does pain radiate to arms and legs _____

Rate present pain on a 1-10 scale (1=minimal 10=severe) _____

Does rest relieve your pain Yes / No Does pain awaken you Yes / No _____times / night

What aggravates your pain most sitting / standing / walking / other _____

What positions are most comfortable? _____

Can you drive? Yes / No Can you climb stairs? Yes / No

What other details you can tell us about your injury or condition _____

_____

_____

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Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the past year? ◯ Yes ◯ No

Have you had any prior Physical Therapy treatments this year? ◯ Yes ◯ No

Medicare Patients: Height_____ Weight_____

Surgical History

Body Region:_____Surgery Type:_____Date:_____,_____, _____

Body Region:_____Surgery Type:_____Date:_____,_____, _____

Body Region:_____Surgery Type:_____Date:_____,_____, _____

Body Region:_____Surgery Type:_____Date:_____,_____, _____

Current Medications

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

Signed: _____ Date: _____