Sievers Sports Medicine Demographics

Patient Name (last)_____(first)_____(initial)_____ DOB_____/_____/_____ Age: _____

Gender: male___ Female____

Address_____ Apt #_____City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone _____ **Patients** SSN _____-_____-_____

Marital Status: S ___M ___W ___D ___Sep___

Employer/School _____Language Preference_____EMAIL:_____

Spouse / guarantor, resp. party (last) _____(first)_____(initial)_____ DOB ____/____/_____

Employer/School _____Phone_____

Address (if diff. from above) _____ Apt _____ City _____ State _____ Zip _____

Is this your emergency contact? _____Yes _____No if no List emergency contact with contact _____

Primary Insurance Policy Holders Name _____DOB ____/_____/_____SSN _____-_____-_____ Relationship to patient _____

Address if different from above_____ apt # _____ City _____State ____Zip_____

We MUST have this information to file your insurance.

If you have secondary ins. We will need at time of visit. If you do not provide we will not retro bill any visits.

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I give permission for medical treatment, including radiological and laboratory procedures to be performed by the physicians and staff of Sievers Sports Medicine. This consent is valued from this day forward. I authorize payments of medical benefits for Sievers Sports Medicine for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize Sievers Sports Medicine to disclose to any person or corporation, which is or may be liable under a contract to Sievers Sports Medicine, the physician(s), the patient, for all or part of Sievers Sports Medicine and physician charges, including but not limited to, insurance companies, workers' compensation carriers, and governmental agencies. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES**. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. MEDICARE AND/OR MEDICAID CERTIFICATION: "I certify that the information given by me in applying for payment under Title XCIII and/or Title XIX of the Social Security Administration is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or it's inter-me diaries/carriers any information needed for this or related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf.

PATIENT RECORD OF DISCLOSURES In general, HIPAA privacy rule gives individuals the right to request a restriction of users and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of that communication, of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. My records/results can be released to 1) Myself only _____ 2) List any other person/s you wish your PHI to be released

to _____ Best way to be contacted 1) Phone if different from above_____

2) Written Communication _____

3) EMAIL: _____ (LIST ABOVE) **if you are under the age of 18** then a parent MUST accompany you to your appt. and bring their ID. Bring any and all x-rays with you to the appt.

Specific to the injury.

Please read and sign that all of the above information is acceptable and correct.

Print Name _____Sign Name _____Date _____/_____/_____

Sievers Sports Medicine **Patient Financial Responsibility / NO SHOW policy** **PLEASE READ AND INITIAL AND SIGN ALL AREAS REQUESTED**

Dear patient: Thank you for choosing **Sievers Sports Medicine** for your healthcare. We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

INSURANCE: You are directly responsible for payment of your medical care and you are expected to pay for any co-payment, deductible, or non-covered amounts AT THE TIME OF SERVICE. Your insurance company may not pay for all of your health care costs.. Insurance policies exclude some non-covered services; however, this does not mean that the services or test are not necessary. It means that the insurance company may not pay for it. Please keep in mind that your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. In order to bill your insurance company, you MUST provide our office with accurate billing information and your insurance card/s. If you do not provide this information at each visit, please expect to pay in full at the time of the office visit for the services rendered. We reserve the right to re-schedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in**. INTIAL**_____

BILLING: As a courtesy to you, we will bill your insurance company for the services rendered. In order to do so, we MUST have complete billing information, picture identification, and your insurance card. If your insurance changes it is your responsibility to provide us with updated insurance information. In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts are usually higher. Your insurance policy, not our office, determines these amounts. You will receive a statement every month from our office showing your account balance. Patient balances are due and payable in full upon receipt of your statement. Delinquent accounts will be transferred to a collection agency when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years**. INITIAL**_____

WORK RELATED or MOTOR VEHICLE ACCIDEN (MVA): We do NOT file health Ins. For work related injury/problems ,or MVA's. If this is found to be a work related injury/problem or MVA and your INS denies payment at any time YOU will be financially responsible for the charges not covered and/or denied by your INS. INITIAL_____

REFERRALS: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be re-scheduled or you may be financially responsibility. Specific coverage issues, however should be directed to your insurance company member services department (number is on insurance card). Please understand that maintaining financial responsibility is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect. **INITIAL** _____

HIPAA Acknowledgement **I understand that**, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that his information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment; directly or in directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand the Notice of Privacy Practices for Decision Point Behavioral Health containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. **I understand that** I may request, in writing that you restrict how many private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. **I understand that** I may revoke this consent at any time, except to the extent that you have taken action relying on consent. If you have any questions about this notice please contact. Decision Point Behavioral Health 180 Lachanview Lane NW , Rochester, MN 55901 1-507-261-7081 **INITIAL** _____

NO SHOW AND CANCELLED APPOINTMENT POLICY

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your appointment or fail to show up for an appointment, you will be charged a "no show" fee of $20.00 per occurrence (due to Federal Regulations, Medicaid patients are exempt from the "no show" charge), however they will be required to write a letter to Sievers Sports Medicine justifying why we should provide them another appointment. We will not file your insurance for this fee. You will be responsible for the $20.00 and a notation will be place in your record. Repeated "no shows" and cancellations of your scheduled appointments may result in your being discharged from care at Sievers Sports Medicine, INC. If you come to your appointment without the proper items necessary for you to be seen this fee may also apply due to the fact that you will have to be rescheduled if you cannot provide the proper information within 15 mins of your appointment time. Example: you need current Insurance and ID at every visit. You need to bring any X-rays, MRIs, CT, etc. to your appointment. If this injury happened at work you will need to bring your employers Workers compensation insurance company name and address along with your adjuster and your claim number. It is not this office's responsibility to get this information for you. For your convenience, we have an ans. service that will allow you to leave a message after-hours if you are unable to call during normal business hours. Our phone number is 575-226-2023 **INITIAL** _____

If you have any questions, please talk to our staff before signing. Patient's Name _____

Patient/Guardian Signature _____ Date _____/_____/_____

Sievers Sports Medicine ***Chief Complaint/Injury Form***

**THIS FORM *MUST* BE FILLED OUT *COMPLETELY* EVERY VISIT!!

IF *THIS IS A* WORK RELATED INJURY, *INFORM RECEPTIONIST IMMEDIATELY IF YOU HAVENT ALREADY!*

Patient Name_____ _todays date: ____/____/_____

What are you being seen for today? _____ ***Right*** ***or*** ***Left*** *inside outside front back* ***OF BODY PART***

*Date of injury **or** onset of symptoms _____/_____/_____ How did the injury/symptoms occur_____*

Where were you injured/symptoms start? __ home __sports __work **(if work please make sure front desk knows immediately)** *__ other*

If** you have pain, is it constant? __No __Yes* ***If yes or sometimes, pls. rate: MARK or CIRCLE BELOW

0	1	2	3	4	5	6	7	8	9	10
										

What makes the pain worse? _____What gives you relief from your pain? _____

Describe pain___ sharp___ dull ___ achy___ shooting___ throbbing__ _intense___ radiating. Are you having any ____ numbness ____tingling

***If** a follow up, are there any new issues **(pertaining to the original injury/symptom)?** If yes explain _____*

If** a follow up, please rate your improvement **since seen last. ***MARK or CIRCLE BELOW***

100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
										

Then rate your overall improvement since injury occurred. ***MARK or CIRCLE BELOW***

100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
										

What treatment/s have you tried? _____rest _____ice _____ elevation _____support (brace) _____other