Sievers Sports Medicine

Patient Information Record

Patient Name (last)____________________________________(first)________________________________(initial)_______ DOB_____/_____/_____

Address____________________________________ Apt #______City___________________ State_____ Zip_________ Home Phone _________________

Work Phone ______________________Cell Phone ________________________Age_____ Gender : Male ____ Female ____SSN ______-_____-________

Marital Status: S ___M ___W ___D ___Sep___ Employer/School _______________________________

Emergency Contact______________________________________Relationship___________________Address __________________________________

City_________________________State______Zip_____________Phone________________

Spouse *or Parent, if minor* (last) __________________________________(first)___________________________(initial)_______ DOB ____/____/_______

SSN _________-______-_________ Phone________________________ Address __________________________________ Apt _____ City ___________

State _____Zip_______________ Employer _____________________________________

*Primary Insurance Company*_________________________________ **Policy Holders Name** ____

DOB ______/______/________SSN _______-______-_________Relationship to Patient___________________ Phone ______________________

Address if different from patient_______________________________ Apt # ________ City _______________State ________Zip_____________

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 its inter-mediaries/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 3) Phone if different from above_________________________________4) Written Communication __________________________________

Patients you **MUST** have current insurance cards (including your blue card and salud card if you are on Medicaid) and an ID. 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. If you have a salud you **MUST** have a referral from your Primary Care Physician, if you do not have this you will **NOT** be seen. If you are more that 15 minutes late for your appt. you will be rescheduled for the next available appt. If you are being referred by another physician/provider you can only be seen for the injury/illness listed on the referral paperwork.

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

Print Name ____ Sign Name ____ Date ___________________