The Sports Medicine and Joint Center

3400 Lomita Blvd., Suite 503, Torrance, CA 90505
Tel. (424) 999-5633 | Fax (424) 201-5701
info@mysportsmd.com | www.mysportsmd.com

☐New Patient ☐Follow-up/Update Date:_____

PATIENT'S LEGAL NAME:

First _____ Middle_____ Last _____ Sex: M F
Social Sec #: _____ DOB: _____ Age: _____ Marital Status: M S W D
Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone _____
Employer: _____ Occupation: _____
School Name (if student): _____ Do we have permission to talk to school: Y N
Email address: _____Religious Preference:_____
Primary Physician Name & Phone: _____

EMERGENCY CONTACT:

NAME: _____ Phone #: _____ Relationship: _____

DATE OF INJURY: _____

RESPONSIBLE PARTY: (If the patient is a minor, person responsible for billing account)

Name: _____ Relationship to patient: _____ Sex: M F
Address: _____ DOB: _____
City, State, Zip: _____ Social Sec: _____
Phone #: _____ Employer: _____

PRIMARY INSURANCE:

Insurance Company: _____Primary Insured's Name: _____
Insured's Group #: _____ Insured's ID #: _____
Insured's Phone #_____ DOB: _____ Soc Sec #: _____

SECONDARY INSURANCE:

Insurance Company: _____ Primary Insured's Name:_____
Insured's Group #: _____ Insured's ID #: _____
Insured's Phone #_____ DOB: _____ Soc Sec #: _____

HOW WERE YOU REFERRED TO US: _____

PLEASE READ: Some insurance companies will not pay your bill if you do not select one of their participating physicians. It is the patient's responsibility to determine if our physician participates in your insurance plan. Payment and/or copayment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including attorney's fees. By signature below, the patient or parent or guardian agrees that the jurisdiction and venue for said action shall be the county of Los Angeles and State of California. Any balances due from patients or parents or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).

SIGNED (Patient or Guardian) _____ Date: _____

AUTHORIZATION AND ASSIGNMENT:

I authorize The Sports Medicine and Joint Center to release information regarding my treatment to my insurance company, to health care providers who have referred me The Sports Medicine and Joint Center and to parties who are involved in my treatment if I have work related injury. I also authorize my insurance benefits to be paid directly to The Sports Medicine and Joint Center or the individual physicians. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and if The Sports Medicine and Joint Center is served with a subpoena for production of records, the undersigned authorizes The Sports Medicine and Joint Center to produce such records under a business records affidavit without the necessity of attendance at a deposition. This above authorization can only be withdrawn or revoked by written notification to The Sports Medicine and Joint Center.

SIGNED (Patient or Guardian) _____ Date: _____

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Consent to Release Information

I, _____, authorize The Sports Medicine and Joint Center to discuss my medical treatment and any billing issues with the following people: (**Please list any family members, friends, legal counsel or school personnel** that we are allowed to discuss your treatment or billing issues with.)

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ _____

Patient Signature Date

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Notice of Privacy Practices

Thank you for choosing The Sports Medicine & Joint Center for your medical needs. The staff of the clinic has always protected the confidentiality of health information by keeping your medical information in our Electronic Medical Records system and refusing to reveal your health information without your written consent. Now state and federal laws also attempt to ensure the confidentiality of this sensitive information.

This **Notice of Privacy** will inform you of our privacy practice and your rights. Our practice and your rights are as follows:

- All staff has been trained to maintain confidentiality of your medical records.
- If you are a parent of a minor, you have a right to the health record of a minor.
- You have the right to limit who among the family has access to your record by telling us who can receive such information by filling out the section below. In the event that you choose not to limit access to family, leave the section below blank.
- The law allows us to use your patient information for treatment, payment, and administrative purposes without your written consent.
- You have the right to your medical record at any time by filling out a form available from the receptionist. It is customary that a nominal fee be assessed for copying services.
- The law does allow treating staff to discuss your treatment without your consent.
- Your record is safeguarded from exposure to casual workers entering the office such as delivery and service personnel.
- We will make every reasonable effort to ensure a confidential space for sensitive conversations between you and our staff.

These rules are to ensure your privacy while under our care. If you have any questions, concerns, or comments about this ***Notice of Privacy***, please contact our office.

I have read and understand the above statements.

_____ _____

Print Name Date

_____ _____

Patient or Parent/Guardian Signature Date

Denial of Access to Medical Record:

I want to exercise my right to limit access to my medical records by my family. Listed below are the family members I **do not** want to have access to my medical records:

_____ _____

_____ _____

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Payment Waiver Form

I, _____, understand that the total amount of my charges at The Sports Medicine & Joints Center is completely and solely my responsibility. I understand that whether or not my insurance is charged for any services rendered by The Sports Medicine and Joints Center I am still completely and solely responsible for paying the total amount charged.

_____ _____

Patient Signature Date

_____

Parent/Guardian Name (Printed) and Signature

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To improve efficiency in the office, and to better serve patients, the office institute the following policies:

(Please read and initial the following items)

_____ It is your responsibility to inform the staff of any insurance changes. The staff will make every effort to verify eligibility and coverage at the time of your visit. If we are unable to do so, you will be required to pay for the visit at the time of service. You will be responsible for billing you insurance for that date of service, should you wish to be reimbursed.

_____ It is imperative that the staff has your current address and phone number. Please notify us of any changes.

_____ Co-payments are due at the time of service. Parents who are divorced are to honor this policy, regardless of whether the financially responsible party is present at the appointment. There is a $25 service charge for the non-payment at the time of service.

_____ There is a $40 charge for all returned checks. Repeat occurrences will result in a "cash only" policy.

_____Statements are sent out monthly. If your account becomes 90 or more days past due it will be forwarded to collections. There will be a 30% collection fee added to your balance. If your account is over 90 days delinquent you will be seen on a "cash only" basis. You will be required to pay your balance as well as to pay up front for future medical services. You will be responsible for billing your own insurance company.

_____ For excessive "outstanding balances", the staff can assist you in arranging a payment plan. There will be a charge for this service.

_____ There is a $5 charge for completion of school forms, if requested any other time than a visit. (Medication forms are exempt). This is not billable to your insurance company.

_____ There is a $15 charge for photocopying of patient charts.

_____ Cancellation Policy: As a courtesy, the staff will do their best to call and remind you of a visit 1-2 days in advance. However, to avoid a $25 charge all appointments must be cancelled 24 hours prior to your appointment time. All "no shows" are charged $25. This $25 charge is not billable to your insurance company.

_____ Late policy: We respect your time and make every effort to see you at your scheduled appointment time. In turn, we expect you arrive on time. When you arrive twenty minutes past your appointment you have missed your appointment and you will need to reschedule.

_____ In accordance with the laws of the State of California, I do not prescribe medication for patients over the phone for a new illness. A visit must be scheduled.

_____ Three "no show" appointments within a twelve month period will result in our office asking you to transfer medical care to another physician.

_____ We only bill primary insurance. Patients will be responsible for billing secondary insurance coverage.

I have read, understand, and agree to the above stated policies.

Patient Name: _____ Date: _____

Patient Signature: _____

Parent/Guardian for minors under 18 years old (please print):_____

Parent/Guardian Signature: _____

History and Physical Information

Date _____ MR# _____

Name:_____ Age:_____DOB:_____ Male/Female
Occupation_____Marital status:_____Spouse's name:_____
Tobacco Use: Yes/No Cigarettes Pipe Cigar Chew Snuff
Alcohol Use: Yes/No Daily Weekly Socially Occasionally

Please check all that apply

Personal History

___Heart Disease
___High Cholesterol
___Thyroid Problems
___Kidney Disease
___Asthma/Lung Disease
___Diabetes
___Head Injury
___High Blood Pressure
___Alcoholism/Substance Abuse
___Cancer
Specify_____

Family History

___Alcoholism
___High Blood Pressure
___Heart Disease
___High Cholesterol
___Asthma/Lung Disease
___Diabetes
___Depression
___Arthritis
___Bleeding Disorders/Blood Clots
___Stroke
___Cancer
___Died at young age for unknown cause
Specify_____

Allergies

_____

_____

Medication/Vitamins

Medication Dosage

_____

_____

_____

_____

Review of Symptoms

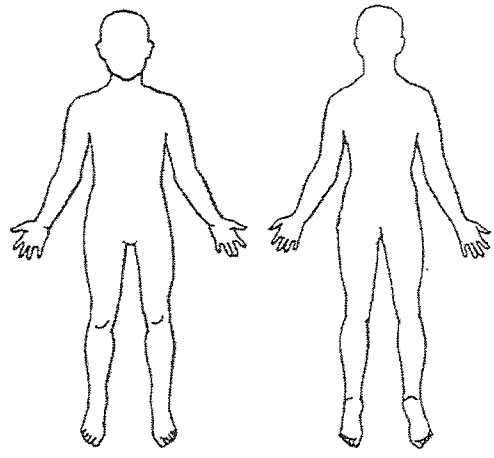
___Fever/Sweats
___Weight loss/gain
___Cough/wheeze
___Shortness of breath
___Palpitations
___Chest pain
___Headaches
___Dizziness
___Memory loss
___Cold/heat intolerance
___Nausea/Vomiting/Diarrhea
___Post concussion symptoms
___Muscle Pain
___Joint pain
___Back pain
___Neck pain
___Abdominal pain
___Heart burn/reflux
___Bloating
___Skin rash
___Easy bruising/bleeding
___Anxiety/Depression
___Bowel /bladder changes
___Fainting

Please circle your pain level

Pain Scale

0-1 No pain
2-3 Mild pain
4-5 Discomforting pain
6-7 Distressing pain
8-9 Intense pain
10 Unbearable Pain

Front Back
R L L R



Surgeries

Type Date

_____

_____

OFFICE USE ONLY:
Vital Signs: BP_____L/R P:_____R:_____ PO2:_____

Are you pregnant ____Yes ___No
Are you _____ Rt hand _____ Lt hand dominant
Did this problem a result from a work injury?
____Yes ____No
Are you currently working? ____Yes _____No
Full or part time _____
If not working, date last worked _____
Is this a litigated case? _____Yes _____No
If yes, attorney name _____

Who referred you ?
_____
Primary Care Physician name:
_____
Address:
_____
_____
Does your Primary Care know why you are here? _____

Are you a student, Where?_____ Grade? _____ Sports? _____
Coach/Trainer Name: _____ Phone number if known: _____
Shoe Size: _____

Chief Complaint

Why are you here today? _____
When did your problem start? _____
Any known injury? _____
Over time is problem getting ____Better ____Worse ____No change
Is the pain? __Constant __Dull __Aching __Intermittent __Sharp __Stabbing __Shooting __Throbbing
Do you have: __Weakness __Stiffness __Loss of Motion __Locking __Catching __Popping __Grinding __Giving way
When do you experience it most? _____
What makes it better? _____
Have you seen another doctor for this? ____Yes ____No
If so, who? _____
What treatments have you tried? __Rest __Ice __Compression __Elevation __Bracing __Physical Therapy __Chiropractor __Acupuncture __Anti-inflammatory Medications __Massage __Exercise __Tylenol __Pain Medications
__Injections: __Cortisone __Trigger Point __Supartz __Hyalgan __Euflexxa __Synvisc
Date of last injection: _____
Has anything helped? _____
R/L Hand Dominant Ht:_____ Wt:_____

Testing for this problem

List all medical test including X-rays, MRI, CT Scan, Nerve Testing and Labs, pertaining to this problem:

Date	*Test Preformed*	*Result*	*Location/Site*