SportsMED
Orthopaedic Surgery & Spine Center

**DATE:** _____ **Account #:** _____

How did you hear about SportsMED? _____

Referring Physician: _____ / Primary Care Physician: _____

**Patient Information:**

Last name: _____ First Name: _____ Middle: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ DOB: _____ SS#: _____

Phone 1: _____ Phone 2: _____ Marital Status: ____ Sex: ____ Email: _____

Ethnicity: _____ Race: _____ Preferred Language: _____ □ Decline to answer

Employer: _____ Occupation: _____ Work Phone: _____

**Insurance Information:**

Primary Insurance: _____ I.D.#: _____ Group #: _____

Secondary Insurance: _____ I.D.#: _____ Group #: _____

**Please complete if insured and patient are not the same for either primary or secondary insurance:**

Name of Insured: _____ Date of Birth: _____ SS#: _____

Address (including City, State, Zip: _____

Employer: _____ Relationship to patient: _____

**Responsible Party if Patient is a Minor:**

Responsible Party: _____ Relationship to Patient: _____

Address (including City, State, Zip): _____

**Emergency Contact:**

Name: _____ Phone #: _____ Relationship to Patient: _____

**Patient Condition Information:**

Please explain reason for visit: _____

Job related injury? □ Yes or □ No (if yes please see front desk) Auto accident? □ Yes or □ No

If condition is an injury or accident, please provide date of injury and state in which it occurred: _____

Briefly explain how the injury occurred: _____

Were you seen in the hospital for this injury? □ Yes or □ No Did you see a SportsMED physician in the hospital? □ Yes or □ No

Name of the hospital in which you were seen? _____

If no injury occurred, provide the date your pain began: _____

# Authorization & Statement of Financial Responsibility

**Last Name:** _____ **First Name:** _____ **Account #:** _____

**CONSENT FOR TREATMENT:** I hereby authorize the performance of any medical procedure, which may be advised and/or recommended by my therapist and/or physician. I authorize the release of any information that may be required or as pertains to my treatment such as operations, consultations, diagnostic tests, physical examinations, etc. A photo-copy will be as valid as the original. I authorize payment directly to the undersigned physician of the surgical and /or emergency benefits, including major medical insurance, if any, payable to me. I authorize the release of any information to insurance carriers concerning my diagnosis and treatments and I assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance for this authorization.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign payment directly to SportsMED for medical benefits otherwise payable to me for their billed services, but not to exceed its charges. Any unpaid deductible and/or estimated co-pay is due and payable at time of service. I understand that charges not payable by insurance is my responsibility and all charges are due in full within 90 days from the date of service; regardless of any insurance pending.

**STATEMENT OF PERMIT PAYMENT OF MEDICARE BENEFITS:** Payment for services rendered is to be made as follows: I request that payment of authorized Medicare benefits be made payable to SportsMED on my behalf for any services rendered to me by SportsMED. I authorize any information needed to determine these benefits payable for services rendered.

**MEDICARE:** I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medial or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf and assign the benefits payable for physician services to SportsMED.

**MEDICAID:** I certify the information given by me in applying for payment under title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the State of Alabama or its fiscal agent any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf.

**TRICARE:** I hereby agree to accept full responsibility for any co-pays or cost shares that are considered part of my Other Health Insurance (OHI) plan even though making these payments may result in SportsMED being paid an amount in excess of the 115% balance billing limit set by Publix Law 102-396. I also understand that SportsMED may bill me for any cost shared or co-payment that is not paid at the time of service.

**WORKER'S COMPENSATION PATIENTS:** I authorize the release of all medical information to my employer, insurance adjuster, and/or case manager assigned to my worker's compensation claim. I further understand that if I am non-compliant with my treatment program and/or appointment that SportsMED may notify the above stated individuals.

**PAYMENT POLICY:** Standard charges have been established for all services provided at SportsMED. The fee for your services will be billed to your insurance company as a courtesy to you. You are required to pay any co-pay and/or unmet deductible amount at the time of service. You will be sent a statement for any remaining balance after your insurance has process your claims. At that time, your entire balance for processed dates of service will be due. If payment arrangements need to be made, please contact our regional billing office. Our policy is to have the entire balance of your account with SportsMED paid within 90 days of your date of service.

**CREDIT POLICY:** In the event that I do not meet the payment terms above and further action is taken on my account, I agree to be responsible for the entire balance due plus up to 50% collection agency fee and/or court cost, including any attorney fees. I authorize SportsMED to verify my employment status with my employer to assist in the collection of my unpaid bill and/or for insurance verification. I have read and understand the terms of this Statement of Financial Responsibility.

**MISSED APPOINTMENTS:** If you cannot make your appointment, please call at least 24 hours in advance to cancel. We reserve the right to charge $25.00 for any non-cancelled appointments.

**RELEASE OF RECORDS:** I authorize SportsMED to disclose all or part of my medical and/or patient account records to my insurance company or association as may be necessary for the processing of any outstanding insurance claims, as well as to any treating physician or healthcare providers involved in myself, or responsible party, medical care to include copies of medical records.

**ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES:** Under federal HIPAA guidelines, all patients are to be provided with the opportunity to review and/or have a copy of our Notice of Privacy Practices which explains how medical information will be used and disclosed. By my signature below I acknowledge having been made aware there is a copy in the waiting room, as well as one attached here for me to take if I choose. I understand I may request a copy or additional copies of this document at any time.

**Patient (or responsible party):** _____ **Date:** _____