Patient Consent for Care and Treatment

As a patient, you have the right to be informed about your condition and recommended surgical, medical, or diagnostic procedure to be used to decide whether or not to undergo any suggested treatments after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is to obtain your permission to perform necessary evaluation to identify appropriate treatment for any identified condition. Consent will remain effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. We encourage you to ask questions if you have any concerns regarding any test or treatment recommend by your health care provider. You have the right to discontinue services at any time.

I voluntarily request an Austin Sports Medicine physician, physical therapist, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Orthopedic Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Austin Sports Medicine.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

Signature of Patient or Personal Representative   Date

FINANCIAL POLICY

Payment

- The **patient is responsible** for the payment of deductibles, co-insurance, co-pays, and all other treatments not covered by their insurance. We bill according to the negotiated rate with your insurance provider and will collect an estimated amount for the services provided. **Payment is due at the time of service**. We will look to the **adult accompanying a minor** for all services rendered to minor patients. For your convenience we will accept checks and most major credit cards.

Insurance

- The **patient is responsible** for knowing the terms of their insurance. All health plans are not the same and do not cover the same services. It is important you contact your insurance company to verify the following for each time you visit our office:
    - If my provider **is in or out of network**
    - If my insurance will **cover these services**
    - If my insurance requires a **referral** (for example, from my Primary Care Physician)
    - If my insurance requires **Prior authorization**

  ***** If a required referral or authorization is not obtained prior to your visit and you choose to be treated, you will be billed as self-pay. Full payment will be due at the time of service.***
- The **patient is responsible** for providing us with complete and accurate billing information. The patient will be responsible for any charges incurred if the information provided is not correct at the time of service.
- As a courtesy, we will verify your insurance benefits with the information provided prior to services and file a claim for you.
- The **patient agrees** to assign the benefits to the doctor, in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits.
- The **patient is** responsible to respond to any additional requests such as Coordination of Benefits, Subrogation/Accident questionnaires, pre-existing, etc. Depending on your benefits, your insurance may not pay for all of your healthcare cost due to pre-existing condition, exclusion of diagnosis, out-of-network, etc. and you will be financially responsible for all non-covered services.
- **If you have questions about your benefits coverage, please contact your insurance directly**.
- The **patient is responsible** for any amount not covered by your insurer. Many insurance companies have additional stipulations that may affect your coverage. If your insurance denies any part of your claim, or if you or your physician elects to continue treatment past your approved period, you will be responsible for your account balance in full.
- In the event your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Instances of the insurance carrier not covering services include but are not limited to: absence of referral or authorization, determination of non-medical necessity, procedure is deemed experimental, your provider is out of network, inactive coverage, exhaustion of contracted benefits, and concurrent services from multiple providers.
- If your insurance company fails to pay your bill or you have a remaining balance due, you will receive a statement. Payment is due on receipt.
- If you have a balance on your account, you will receive a total of three (3) statements. Should your account become more than 90 days past due, your account will be sent to a collection agency.
- If we cannot verify your benefits prior to your scheduled appointment time, a deposit equal to the self-pay amount will be due at the time of service. If we later receive a payment from your insurer, we will refund you for any overpayment.

Self-Pay Disclosure

- MD Office Visit: $400 (MD consult including X-Ray)
- PT Evaluation- $250
- PT Re-evaluation- $200
- PT Follow-up Visit- $150
- Dry Needle: $50 per unit (8-15 minutes = 1 unit)

Medical Records Requests

- All records requests require a signed Medical Release Form. Please allow up to 10 business days for all records requests to be processed.
    - Medical Records <10 pages = no charge
    - Medical Records > 10 pages = $25
    - Billing Records (flat rate fee) = $25
    - FMLA Paperwork (filled out by office) = $25
- All other requests for records will be billed according to the Texas Administrate Code Title 22 Part 9 Chapter 165 Rule 165.2, which states: No more than $25 for the first 20 pages; then, $0.50 per page for every copy thereafter, actual cost of mailing of shipping and a reasonable fee not to exceed $15 for executing an affidavit. Charge for x-ray/diagnostic imaging is $8 per copy of an imaging study.

By my signature below, I certify that I have read, understand and agree to be bound by the statements and terms in this Financial Policy document (2 pages).

Signature: ______________________________________ Date: ______________

HIPAA Privacy and Release of Information Authorization

I hereby authorize Austin Sports Medicine and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.
If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

____

Patient Printed Name Date

____

Patient Signature

Name: ______________________________
DOB: ______________________________
Chart: ______________________________
Age: ______________________________
Date: ______________________________

AUSTIN SPORTS MEDICINE

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PATIENT INFORMATION

**** All sections MUST be completed. If not applicable, please indicate as "N/A" ****

Today's Date ______________________

Patient Information:

Last Name ____________ First Name ____________ M.I. ____ Nickname ________ Birth Date ________
Age ____________ Sex ____________ Marital Status: ☐ S ☐ M ☐ W ☐ D
Social Security No. ____________________ Driver's License State and # ________________
Permanent Address ____________________ Apt # ____ City ____________ State ____ Zip ______
Home Phone ______________ Cell Phone ______________ Work Phone ______________
Email ______________________
Preferred Language ________ Race: ☐ Decline ☐ Asian ☐ African American ☐ Caucasian ☐ Native American
Ethnicity: ☐ Decline ☐ Hispanic or Latino ☐ Non Hispanic or Latino
Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker Start Date ________ Stop Date ________
Occupation ______________________ Employer/School Name ______________________
Primary Care / Family Physician's Name ______________________________
Pharmacy Name ____________ Phone ____________ Address or Intersection ________________
Have you been treated by one of our physicians? ☐ No ☐ Yes by Dr. ____________ Approx Date ____________
Was your injury sustained on the job? ____________ Has a claim been filed with your employer? ____________

Referred By:

☐ Doctor ☐ Hospital/Clinic ☐ Patient ☐ Friend/Co-Worker ☐ Family Member ☐ Employer ☐ TV ☐ Internet ☐ Radio ☐ Other
If referred by a Physician: Last Name ______________ First Name ______________

Emergency Contact: ______________________ Relationship to the patient: ______________________ I authorize Austin Sports Medicine to release treatment/account information to the following people: ______________________

WORKER'S COMPENSATION DISCLOSURE

If you are seeking care at this facility for an injury/condition that occurred due to work, please note that we are required by the Texas Worker's Compensation law to handle your claim with your employer's workers compensation insurance carrier (pursuant to TWCC Rule 120.1 & 120.0). **Please mark the applicable statement**:

☐ **I certify that my injury/condition IS work related** ☐ **I certify that my injury/condition is NOT work related**

MEDICAL INSURANCE INFORMATION

Please bring a copy of your insurance card(s) to your visit. Our office will make a copy of the front and back of your card(s) in order to file claims appropriately. Failure to provide a copy of your insurance card(s) will result in visits being treated as self-pay and the patient will be responsible for the full cost of the visit at time of service.

Name: ______________________________

DOB: ______________________________

Chart: ______________________________

Age: ______________________________

Date: ______________________________

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MEDICAL HISTORY

Today's Date ____________________ Age ______________ Height ____________ Weight __________

Primary Physician ____

ILLNESSES / REVIEW OF SYSTEMS (Provide details to all yes answers)

Yes	No	Details	Medication
☐	☐	High Blood Pressure ________	________
☐	☐	Heart Problems/Pacemaker/Chest Pain ________	________
☐	☐	Diabetes ________	________
☐	☐	Cancer ________	________
☐	☐	Asthma/Lung Disease/Shortness of Breath ________	________
☐	☐	Hepatitis/Liver Disorders ________	________
☐	☐	Thyroid Problems ________	________
☐	☐	Bleeding Problems/Stroke ________	________
☐	☐	Blood Clots/Phlebitis ________	________
☐	☐	Kidney Disease ________	________
☐	☐	Frequent Bladder Infections ________	________
☐	☐	Stomach Ulcer/Bleeding ________	________
☐	☐	Depression/Mental Illness ________	________
☐	☐	Recent Weight Change ________	________
☐	☐	Eyes, Vision Change ________	________
☐	☐	Ear, Nose, Throat, Mouth Problems ________	________
☐	☐	Seizure ________	________
☐	☐	Osteoporosis ________	________
☐	☐	Numbness/Tingling ________	________
☐	☐	Other Illness/Hospitalization ________	________
☐	☐	Previous Bone or Joint Problems ________	________
☐	☐	Other Sports Injury ________	________

DRUG ALLERGIES (Check yes or no)

Yes	No	
☐	☐	If yes, provide details ________

____

____

LATEX ALLERGIES (Check yes or no)

Yes	No	
☐	☐	If yes, provide details ________

____

OTHER MEDICATIONS (current/recent)

Yes	No	
☐	☐	Diuretics
☐	☐	Blood Thinners
☐	☐	Steroids/Cortisone
☐	☐	Weight Control
☐	☐	Sleeping Pills
☐	☐	Antibiotics
☐	☐	Pain Pills
☐	☐	Aspirin
☐	☐	Anti-inflammatories (e.g. Advil)
☐	☐	Herbals/Vitamins/Supplements
☐	☐	Other

____

☐ ☐ **PREVIOUS SURGERY** (type and dates) ______________________________

____

☐ ☐ **PREVIOUS & FUTURE DENTAL PROCEDURES** (type and dates) ______________________________

____

☐ ☐ **FAMILY HISTORY** (illness, reactions to anesthesia) ______________________________

____

☐ ☐ **RECENT TEST RESULTS** (EKG, check x-ray, blood or HIV tests, etc.) ______________________________

____

☐ ☐ **DRINK?** (how often?) ____________

☐ ☐ **SMOKE** (pack/day) ____________

WOMEN ONLY

Pregnant? ____________

Birth Control (type) ____________

Date Last Period Started ____________

For Office Use only	*Date / Initials*
History Reviewed / Updated	____________
History Reviewed / Updated	____________
History Reviewed / Updated	____________

Name: ______________________
DOB: ______________________
Chart: ______________________
Age: ______________________
Date: ______________________

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REVIEW OF SYSTEMS

NAME ______________________ DATE ______________ CHART# ______________

Please check which applies to you and describe, or check "No problem:"

General: ☐ Recent weight changes ☐ Fever ☐ Weakness ☐ Fatigue ☐ Headaches ☐ No problem

Skin: ☐ Rashes ☐ Eruptions ☐ Dryness ☐ Jaundice ☐ Swelling ☐ Changes in skin/hair/nails ☐ Discoloration ☐ No problem

Eyes: ☐ Blurred vision ☐ Double vision ☐ Burning eyes ☐ Seeing spots ☐ No problem

Ears/Nose/Throat: ☐ Soreness/redness of gums ☐ Hoarseness ☐ Difficulty swallowing ☐ Head colds ☐ Nasal drainage ☐ Obstruction ☐ Sinus pain ☐ Earache ☐ Hearing loss ☐ Hearing aids ☐ No problem

Musculoskeletal: ☐ Joint pain ☐ Swelling ☐ Stiffness ☐ Deformity ☐ No problem

Pulmonary: ☐ Difficulty breathing ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Shortness of breath ☐ No problem

Neurological: ☐ Fainting ☐ Blackouts ☐ Paralysis ☐ Memory loss ☐ Dizzy spells ☐ No problem

Cardiovasular: ☐ Chest pain ☐ Rheumatic fever ☐ Rapid heartbeat ☐ Leg swelling ☐ Heart valve problems ☐ Varicose veins ☐ Heart attack ☐ No problem

Endocrine: ☐ Fatigue ☐ Hot or cold intolerance ☐ Excessive sweating, thirst, hunger ☐ No problem

Gastrointestinal: ☐ Decrease in appetite ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Hemorrhoids ☐ Reflux ☐ Blood in stools ☐ Ulcers ☐ No problem

Genitourinary: ☐ Urinary frequency/pain ☐ Blood in urine ☐ Difficulty voiding ☐ Incontinence ☐ No problem

Male: ☐ Hernia ☐ Testicular problems ☐ Penile problems ☐ Impotency ☐ Infertility ☐ No problem

Female: ☐ Vaginal discharge ☐ Pain ☐ Discomfort ☐ No problem

Hematological/Lymphatic: ☐ Anemia ☐ Swollen glands ☐ Easy bruising or bleeding ☐ Swollen glands ☐ No problem

Psychological: ☐ Nervousness ☐ Mood swings ☐ Insomnia ☐ Nightmares ☐ Depression ☐ Irritability ☐ No problem

Other: ______________________

Name: ______________________________

DOB: ______________________________

Chart: ______________________________

Age: ______________________________

Date: ______________________________

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CLINICAL INFORMATION

What is being examined today? ____________________ ☐ Right ☐ Left Dominant Hand ☐ Right ☐ Left

How long have you had this problem? ____________________ Date pain started? ____________________

How did the problem first occur? ______________________________

Have you seen a physician for this problem before? ☐ No ☐ Yes Doctor ____________________

Have you had a previous injury in this area? ☐ No ☐ Yes If yes, please describe ____________________

Have you had surgery on this area? ______________________________

What physician did your surgery? ______________________________

Sports/Hobbies ____________________ Level (e.g., High School, Recreational) ____________________

What makes your pain better? ______________________________

What makes your pain worse? ______________________________

Medications used for this problem: ______________________________

Do you have Numbness and Tingling? ______________________________

Do you have swelling? ______________________________

Have you had any tests for this problem? ☐ MRI ☐ X-Ray ☐ Other: ____________________

Does your pain radiate (move)? ______________________________

Do you have weakness? ______________________________

Pain Drawing:

Please indicate the locations of your pain with a "X":

Rate your pain: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

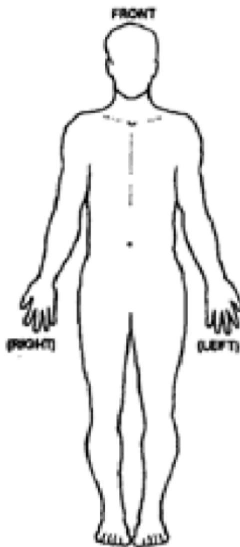
Describe you pain check all that apply:

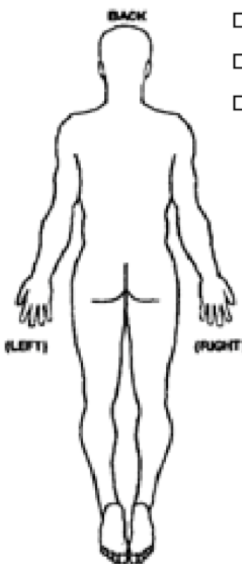
☐ Sharp ☐ Pins and needles ☐ Worse at night

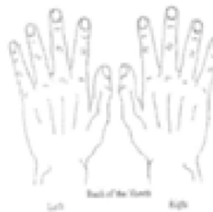
☐ Aching / Throbbing ☐ Dull ☐ Getting better

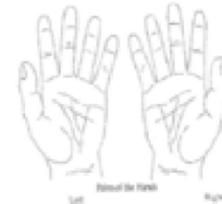
☐ Burning ☐ Constant ☐ Unchanged

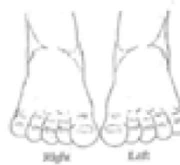
☐ Comes and goes ☐ Worse in morning ☐ Getting worse

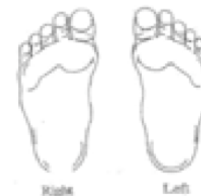












LATE CANCEL & NO SHOW POLICY

We understand there may be extenuating circumstances where you must miss an appointment. However, we require at least 24 hours' notice if you are unable to attend your scheduled appointment. This will allow the spot to be offered to patients urgently need treatment and on a lengthy waitlist.

Not showing up for an appointment for any reason will result in:

$50 fee for your 1st missed appointment.

$75 fee for your 2nd missed appointment.

$100 fee for your 3rd missed appointment.

If an office appointment is not canceled at least 24 hours in advance, you will be charged:

$25 for your first late cancelled appointment.

$50 for your 2nd late cancelled appointment.

$75 for your 3rd late cancelled appointment.

***Monday** appointments must be cancelled **by 4pm the Friday before** to avoid a late cancellation charge.

Surgical No-Show/Cancellation Fee = $250 (cancellation of any surgical procedures requires at least 72-hour notice).

These charges are not covered by your insurance and will have to be paid by you personally.

As a courtesy to all our patients, appointments will be rescheduled if you are more than fifteen (15) minutes late, and you will incur a no-show fee.

If you repeatedly miss scheduled appointments (i.e. 3 or more No Shows and/or late cancels) and our staff is unable to contact you for a period of time, all remaining scheduled appointments will be cancelled. Additionally, missing multiple scheduled appointments may result in any or all the following:

-Future scheduling of appointments will be limited to same day, subject to availability.

-Deposit or prepayment for the cash-based value of the future visit.

-Discharge of the patient from further treatment at ASM.

**A referral to another provider may be provided upon written request.*

You are responsible for your schedule. Make a habit of double-checking your next visit. Note changes to your schedule right away.

Not showing up for your appointment, or appointments canceled less than 24 hours in advance affects us all. Available appointments are in high demand and your early cancellation will give another person the possibility to have the treatment they need.

We consider it an honor and privilege to be of service to you. We appreciate your consideration and cooperation to keep the schedule accurate so we can get all patients back to what they love!

I have read and understand these policies.

I ___________________________________have read and understand these policies.
(PRINT NAME)

PATIENT SIGNATURE:______________________________ DATE: ____________________

How Did You Hear About Us?

- ☐ Google Search
- ☐ Social Media
- ☐ Yelp
- ☐ Referral from your doctor __________________
- ☐ Friend/family recommendation ______________
- ☐ Other __________________