PATIENT INFORMATION

NAME (LAST FIRST MIDDLE INITIAL)			ADDRESS		
CITY	STATE	ZIP	CELL PHONE	HOME PHONE (A/C & NO.)	
DATE OF BIRTH	MARITAL STATUS	SEX	SOCIAL SECURITY NUMBER	TDL #	
	☐ S ☐ M ☐ D ☐ W	☐ MALE ☐ FEMALE			
EMAIL ADDRESS		EMPLOYER			
ADDRESS OF EMPLOYER		OCCUPATION		BUS. PHONE (A/C & NO.)	

SPOUSE OR PARENT INFORMATION

NAME (LAST FIRST MIDDLE INITIAL)	RELATIONSHIP	ADDRESS		PHONE
EMPLOYER & ADDRESS		DOB	BUS. PHONE (A/C & NO.)	SOCIAL SECURITY NUMBER
EMERGENCY CONTACT	RELATIONSHIP	ADDRESS		PHONE

INSURANCE GUARANTOR INFORMATION

NAME (LAST FIRST MIDDLE INITIAL)	RELATIONSHIP	ADDRESS		PHONE
EMPLOYER & ADDRESS		DOB	BUS. PHONE (A/C & NO.)	SOCIAL SECURITY NUMBER
EMERGENCY CONTACT	RELATIONSHIP	ADDRESS		PHONE

RACE

☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER RACE ☐ REFUSED ☐ UNKNOWN

ETHNICITY

☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ UNKNOWN ☐ REFUSED

PREFERRED LANGUAGE_____

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE		ADDRESS OF PRIMARY INSURANCE COMPANY		
INSURED'S NAME	DOB	IF GROUP INSURANCE, NAME OF EMPLOYER	GROUP NO.	ID NO.
SECONDARY INSURANCE COVERAGE		ADDRESS OF SECONDARY INSURANCE COMPANY		
INSURED'S NAME DOB		IF GROUP INSURANCE, NAME OF EMPLOYER	GROUP NO.	ID NO.

CO PAY	HMO	PPO	MEDICARE NUMBER	MEDICAID NUMBER

Payment is expected at the time services are rendered unless prior arrangements have been made.

ASSIGNMENT OF BENEFITS I hereby assign payment of medical insurance benefits to the physician or physicians that rendered treatment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SIGNED _____ DATE _____, 20____

RELEASE OF MEDICAL INFORMATION I consent to the release of any medical information TO MY INSURANCE COMPANIES.

SIGNED _____ DATE _____, 20____

MR#_____

SPORTS MEDICINE ASSOCIATES

ACKNOWLEDGMENT OF RECIEPT
NOTICE OF PRIVACY PRACTICES
(HIPAA)

I Acknowledge that I have received/reviewed the Notice of Privacy Practices from Sports Medicine Associates of San Antonio.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Printed Name of Legal Representative **Relationship**

Consent for Physician Care and Treatment

I, **(Patient's printed name)** _____ hereby agree and give my consent for *Sports Medicine Associates of San Antonio, PA* to provide physician services considered necessary and proper for the assessment, diagnosis, and treatment of my physical condition. Treatment plan will be reviewed with me prior to implementation.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ *If patient is under18 years of age*

CONSENT FOR RELEASE OF MEDICAL INFORMATION

☐ **YES** The practice may discuss my medical condition, treatment, appointments, prescriptions, pathology and/or lab results with the following person(s) including disclosure by telephone, fax or email.

NAME **RELATIONSHIP** **PHONE**

_____

NAME **RELATIONSHIP** **PHONE**

_____

SPORTS MEDICINE ASSOCIATES
Any Athlete. Any Injury. Anytime.

MR#_____

Patient Information

Sports Medicine Associates of San Antonio would like to welcome you to our office. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be given for you records.

1. **PAYMENTS.** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of you appointment. We accept cash, checks, Visa, MasterCard or American Express.
2. **CANCELLATIONS.** If you need to cancel your appointment, be sure to call us at least 24 hours before your scheduled appointment.
3. **APPOINTMENT TIME.** We ask that our patients arrive on time for their appointments; this will facilitate our ability to see you as scheduled. In an effort to serve all our patients well, patients arriving past their appointment time may be rescheduled. Occasionally we encounter medical emergencies or unforeseen circumstances that require immediate attention. On these occasions we may run late.
4. **HMO & PPO REFERRALS.** If your policy requires written authorization from your Primary Care Physician, we will request authorization, in advance, for established patients only. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in contact with your physician to ensure your visit is pre-approved, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION.** Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a new Patient Information Form and may not be changed over the telephone.
6. **YOUR ATTENDING PHYSICIAN.** Once you have selected a physician, he will be your Attending Physician throughout your treatment at our office. If, during the course of your initial treatment your physician is unavailable, another physician may treat you in his absence. You will return to the care of your Attending Physician upon his return.
7. **MEDICATION REFILL REQUESTS.** Please contact your pharmacy first. They will call our office for authorization of the refill.
8. **AFTER HOUR CARE.** In an emergency, please dial the main office number at (210) 699-8326 and leave a message with the answering service, the physician on-call will return your phone call as soon as possible. In a life-threatening emergency, call 911.
9. **MEDICAL RECORDS COPY REQUESTS.** Requests for copies of your medical records must be made in writing on a form provided by our offices. Our office will respond within 15 days to a properly completed written request. **FEES:** As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge the following for copying medical records.
    - $25.00 for the first 20 pages, 50 cents for each additional page thereafter, and the actual cost of mailing, shipping or delivery if applicable.
    - $10.00 per copy for films and diagnostic imaging studies.
    - Copies of medical records will be retained until the payment is received, unless requested by a licensed Texas healthcare provider or any American or Canadian licensed physician for acute or emergency medical care, or to support an application for disability or other benefits or assistance under Aide to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, Federal Old-Age and Survivors Insurance or the Veterans Administration.
10. **COMPLETION OF FORMS.** As per the rules adopted by the Texas State Board of Medical Examiners, our office will respond to requests for the completion of medical forms following the receipt of a $15.00 fee. Forms will be completed as soon as possible.

"I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

_____ _____

Signature Date

SPORTS MEDICINE
ASSOCIATES

Every Athlete. Every Injury.

Patient Evaluation Form

Name _____ DOB _____ Age _____

Right _____ Left _____

Knee _____ Foot _____ Ankle _____ Shoulder _____ Elbow _____ Hand _____ Hip _____ Other _____

Date of Onset/or Injury _____ School _____

Which Sport _____ Work Injury _____

Trainer _____ PCP(Primary Doctor) _____

Circle all that apply

Type of Pain:	Aching Burning Dull Piercing Sharp Throbbing
What Makes it Worse:	Bending Climbing Stairs Descending Stairs Lifting Movement Pushing Sitting Standing Walking
What Makes it Better:	Brace/Splint Elevation Exercise Heat Injection Massage Pain Medication Mobility Physical Therapy Rest Ice Stretching
Symptoms	Bruising Crepitus Decreased Mobility Weakness Difficulty going to sleep Instability Limping Locking Night-Time Awakening Numbness Popping Swelling Tingling Tenderness Spasms

Patient Signature _____ Date _____