Today's Date _____/_____/_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Birthdate / /	Age Sex □ M □ F □ T
Street Address	City	State Zip Code	Home Phone Number ( )	
Cell Phone Number ( )	**E-Mail Address (To be used for appointment reminders)**		Social Security - -	
Occupation	Employer	Employer Phone Number		

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Do you have a living will? □ YES □ NO

Pharmacy:

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION **(information used for patient balance statements)**

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )

Occupation	Employer	Employer Address	Employer Phone Number
			( )

INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)
	- -	/ /	/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)
		/ /		

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number
		( )	( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials.

_____ _____

Patient/ Guardian Signature Date

BODYGUARD SPORTS MEDICINE

Name: _____

Date of Birth: _____ Today's Date: _____

Age: _____ Dominant Hand: □ R □ L Height: _____ Weight: _____

Primary Care Physician (PCP): _____

Were you referred by a Physician? □ No □ Yes, who? _____

Chief Complaint: Why are you here today?

_____

_____

Did your problem result from a specific injury? □ No □ Yes, Date of injury: _____

Can you describe the injury? If no injury, how did the problem start?

_____

_____

Symptoms: What symptoms are you currently experiencing? (Please check all that apply)

□ Pain □ Weakness □ Swelling □ Instability □ Stiffness / Motion Loss
□ Locking □ Grinding □ Clicking □ Catching □ Numbness / Tingling

□ Other: _____

Quality: Describe the symptoms: □ Sharp □ Stabbing □ Burning □ Shooting
□ Dull □ Throbbing □ Achy □ Radiating

Duration: How long have you had symptoms? _____

Location: Where are your symptoms, specifically? _____

Timing: How often do you have symptoms? □ Occasional □ Frequent □ Constant
When do symptoms occur? □ At Rest □ With Activity □ Morning □ Night

Severity: (rate: 0=none to 10=severe, please circle) 0 · 1 · 2 · 3 · 4 · 5 · 6 · 7 · 8 · 9 · 10

What makes your symptoms *worse*? _____

What makes your symptoms *better*? _____

Have you had any prior injuries to the area? □ No □ Yes: _____

Previous Treatment: Have you had any prior treatment for this problem?

□ None □ Physical Therapy □ Medications: _____

□ Injections □ Chiropractor □ Surgery: _____

Have you had any tests for this problem? □ No □ X-rays □ MRI scan □ CT scan

When and where? _____

Past Orthopedic Injuries:

□ None _____

Medical History: (Please check previous or current medical conditions)

□ None	□ Anemia	□ Diabetes	□ Liver Disease
	□ Arthritis	□ Heart Disease/CAD	□ Osteoporosis
	□ Asthma	□ Hepatitis	□ Prostate
	□ Blood Clots/DVT	□ High Blood Pressure	□ Stomach Ulcer/Reflux
	□ Cancer _____	□ High Cholesterol	□ Stroke/Seizures
	□ COPD/Lung Disease	□ HIV/AIDS	□ Thyroid Disease
	□ Depression	□ Irregular Heartbeat	□ Vascular Disease

□ Other: _____ _____ _____

_____ _____ _____

Surgical History: (Please list ALL previous surgeries/operations and the dates they were performed)

□ None _____ _____ _____

_____ _____ _____

Current Medications: (Please list names of all drugs and doses/amounts you are taking)

□ None _____ _____ _____

_____ _____ _____

Allergies to Medications: Have you experienced an allergic reaction to any prescription drugs?

□ No □ Yes, Name of the drug? _____ _____

What was the reaction? _____ _____

Social History:

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Hobbies: _____

Do you smoke? □ No □ Yes: _____ packs/day for _____ years

Do you drink alcohol? □ No □ Rare □ Social □ Daily

Family History of Medical Conditions: (Please list any medical problems that run in your family)

□ None _____

Review of Systems: Do you experience any of these symptoms? (Please check all that apply)

1.	*General:*	□ Fatigue	□ Weight gain/loss	□ Fever/Chills	□ Insomnia
2.	*HEENT:*	□ Vision change	□ Hearing loss	□ Sinus pain	□ Sore throat
3.	*Cardiovascular:*	□ Chest pain	□ Palpitations	□ Edema	□ Poor circulation
4.	*Respiratory:*	□ Cough	□ Short of breath	□ Wheezing	□ Pneumonia
5.	*Gastrointestinal:*	□ Nausea/Vomiting	□ Indigestion/Reflux	□ Diarrhea	□ Constipation
6.	*Genitourinary:*	□ Frequent urination	□ Difficult to urinate	□ Painful to urinate	□ Bloody urination
7.	*Skin:*	□ Rash	□ Hives	□ Sensitive skin	□ Easy scarring
8.	*Neurological:*	□ Headache	□ Dizziness	□ Seizures	□ Tremor
9.	*Psychiatric:*	□ Depression	□ Anxiety	□ Mood swings	□ Stress
10.	*Endocrine:*	□ Hypoglycemia	□ Diabetes	□ Thyroid	□ Hot flashes
11.	*Hematologic:*	□ Easy bruising	□ Easy bleeding	□ Anemia	□ Blood clots
12.	*Immunologic:*	□ Seasonal allergies	□ Food allergy	□ Infections	□ Swollen glands

Signature: _____ Date: _____

MD Signature: _____ Date Reviewed: _____

BodyGuard Sports Medicine

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid on the day of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

4. If payment is not received within a reasonable amount of time from the guarantor or if we receive returned mail as undeliverable we will place your account with an outside collection agency.

5. Returned checks will be subject to a returned check fee. A $25 fee may be charged for missed appointments that are not cancelled by the patient prior to the scheduled appointment time.

6. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

7. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

8. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at _____. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at_____. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.

9. **ADVANCE DIRECTIVE:** □ I have executed an Advance Directive □ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date

If other than patient

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

BodyGuard Sports Medicine

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information(PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

You have the right to request that we restrict how we use protected health information about you for treatment, payment, and health care operations. We are not required to agree to this restriction if your request is not feasible or it impedes our ability to provide the treatment you need, but if we do accept your request, we shall honor that agreement.

The practice provides this from to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I acknowledge receipt of the Notice of Privacy Practices.

_____
Printed Name of Patient or Representative

_____ _____
Signature Date

Relationship to Patient (if other than patient) _____

□Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness _____
Printed Name- Practice Representative

Witness _____ _____
Signature Date

Permission to Treat a Minor

(THIS IS DEFINED AS UNDER THE AGE OF 18)

I hereby give permission to the physicians, physician assistants, and nurse practitioners of BodyGuard Sports Medicine to perform treatment, surgical, medical or diagnostic procedures emergent or non-emergent that would be necessary to treat my child,

child's name

for his/her condition. I understand that I or another responsible and knowledgeable adult should accompany my child for routine care. If this is not possible with teenagers, I hereby consent to their treatment during such absence.

This permission slip will be used, in addition, to making an effort to contact parents or legal guardians in the case of an emergency.

BodyGuard Sports Medicine reserves the right to make results of drug testing of minors, whether requested by a parent or employer or prospective employer, available to the parent or guardian.

The physicians of BodyGuard Sports Medicine reserve the right to discuss the results of all testing and treatment with the parents of the minor when the medical provider feels this is necessary for the best care of the minor.

Parent or Guradian Signature *Date*

Relationship

Signature of Minor over the age of 12 *Date*

Signature and Written Name of Witness *Date*