PATIENT INFORMATION

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

RACE

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

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

ETHNICITY

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

PREFERRED LANGUAGE_____

SPOUSE OR PARENT INFORMATION

NAME (LAST FIRST MIDDLE INITIAL)	RELATIONSHIP	ADDRESS		PHONE (A/C & NO.)
EMPLOYER & ADDRESS		DOB	BUS. PHONE (A/C & NO.)	SOCIAL SECURITY NUMBER
NEAREST RELATIVE (NOT LIVING WITH PATIENT)	RELATIONSHIP	ADDRESS		PHONE (A/C & NO.)

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS OR PERSONAL REPRESENTATIVE

❑ **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. **IF YES, PLEASE LIST NAMES BELOW.**

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

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. **email address**

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 ____

SPORTS MEDICINE
ASSOCIATES

Every Athlete. Every Injury.

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 your records.

1. ***PAYMENTS.*** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your 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.

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 HOURS CARE.*** In an emergency, please dial the main office number at (210)699-8326 and leave a message with the answering service, and 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 the $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 _____ ***Date Of Birth*** _____ ***Age*** _____

☐ Right ☐ Left

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

Date of Onset/Or Injury _____ ***School*** _____

Which Sport _____ ***Injury at Work*** _____

Trainer _____ ***PCP*** _____

Circle all that apply below:

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 meds	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

_____ _____

Signature ***Date***

Sports Medicine Associates of San Antonio Notice of Privacy Practices

Effective April, 2013 **Updated January 2014**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 210-699-8326
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice. **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.** For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

SPORTS MEDICINE ASSOCIATES

OF SAN ANTONIO

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**