

ARIZONA SPORTS MEDICINE CENTER

PHYSICIAN: Waslewski Freedberg Peterson Dean Sahasrabudhe **DATE:** _____
(Circle One)

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Home# _____ Work# _____ Cell# _____ Email: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Date of Birth: _____ Gender: Female Male Social Security # _____

Marital Status: (Circle One) Married Single Divorced Separated Widow(er)

Employer/School: _____

Employment Status: __Employed __FT __PT __Not Employed __Retired __Student __Active Duty

Emergency Contact: _____ Relation: _____ Phone: _____

Responsible Party/Insured Party Information (Please fill out completely if other than self)

Responsible Party: **Self** Last Name: _____ First Name: _____

Date of Birth: _____ Relationship: _____ Gender: F M SSN # _____

Address: _____ City: _____ State: _____ Zip: _____

Home# _____ Work# _____ Cell# _____ Email: _____

Responsible/Insured Party's Employer: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Policy ID#: _____ Policy ID#: _____

Group #: _____ Group #: _____

If the primary policy holder is anyone other than yourself, please fill out Responsible Party/Insured Party information above

I have read the Financial Policy: _____ (Signature)

Arizona Sports Medicine Center

Gary Waslewski, MD • Douglas Freedberg, MD • Charles Peterson, MD
Erik Dean, DO • Amit Sahasrabudhe, MD

Patient Name: _____ DOB: _____ Height: _____ Weight: _____
Today's Ailment (brief description of onset): _____

Date of injury or onset of problem: _____ Affected Side: L R
Dominant Side: L R

What is your occupation? _____
Work related? Yes No Auto accident? Yes No Attorney involved? Yes No
Have you had x-rays taken? Yes No If yes, where? _____
Have you had an MRI? Yes No If yes, where? _____
Drug allergies: Yes No Please list drug and reaction: _____

Primary Pharmacy: _____
Cross Street: _____
Phone Number: _____
Fax Number: _____

Daily Medications (please include pain meds, herbs, vitamins, OTC,...)

Name	Dosage/Strength	Times/day

Past Surgical History (list type and date):

Past Medical/Hospital History (Illnesses/Conditions):

Do you exercise? Yes No How often? _____
What type? (running, biking, etc.) _____
Do you smoke? Yes No Packs/day: _____ Years: _____
Do you drink alcohol? Yes No Drinks/week: _____
Are you now, or could you become pregnant? Yes No

Do you now or have you ever had?		
Anemia.....	Yes	No
Diabetes.....	Yes	No
Cancer/Type:_____	Yes	No
Kidney/Bladder Trouble.....	Yes	No
High Blood Pressure.....	Yes	No
Heart Trouble.....	Yes	No
Bleeding Disorder.....	Yes	No
Asthma.....	Yes	No
Neurological Disorder/Seizures.....	Yes	No
Depression.....	Yes	No
Stroke.....	Yes	No
Thyroid Disorder.....	Yes	No
Ulcer/Stomach Problems.....	Yes	No
Hepatitis.....	Yes	No
Arthritis/Gout.....	Yes	No
Phlebitis/Blood Clots.....	Yes	No
AIDS/HIV.....	Yes	No
Substance Abuse.....	Yes	No

Family History: Please list age and state of health

Adopted?	Yes	No
Father	Age: _____	_____
Mother	Age: _____	_____
Siblings	#Brothers: _____	#Sisters: _____
	Age: _____	_____
	Age: _____	_____
	Age: _____	_____
Children	#Sons: _____	#Daughters: _____
	Age: _____	_____
	Age: _____	_____
	Age: _____	_____

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes No
If yes, who and what is their age?

Have you or any blood relative younger than 50 ever had a serious reaction to anesthesia? Yes No
If yes, who and what is their age?

The above information is, to the best of my knowledge, a true statement of my current condition.

Signature: _____ **Date:** _____

Patient Information (continued)

What are we seeing you for today? _____ Date of illness/injury: _____

May our office leave messages on your voicemail or answering machine regarding your healthcare, including but not limited to appointments, surgery, test results, or other necessary treatment information at the stated number on this form?

Yes No

May our office leave messages with family members, friends, or other individuals that answer a call placed at the stated number on this form?

Yes No

Authorization to release information: I hereby authorize Arizona Sports Medicine Center to release any information required in the course of my examination or treatment to the stated insurance companies.

Signature (Patient or parent, if minor): _____ Date: _____

In order to control the cost of billing, Arizona Sports Medicine Center requests payment of all co-payments at the time of service.

_____ (Initial, if applicable) If you are **Self-pay**, please pay the balance in full at the time of service. In the event that you are unable to pay the balance in full, please advise us prior to time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collections.

Workman's Compensation (if applicable)

Insurance Carrier: _____ Claim # _____ Date of injury: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjuster: _____ Phone: _____

Nurse Case Manager: _____ Phone: _____

_____ (Initial) We will bill your worker's compensation carrier for your charges. Please note you will remain financially responsible for any and all charges should your carrier deny coverage or your claim is contested.

ARIZONA SPORTS MEDICINE CENTER

Summary of Privacy Practices

As of April 14, 2003 new federal laws mandated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is concerning patient privacy and access to medical records. The purpose of this brochure is to outline how these new laws affect you as a patient of Arizona Sports Medicine Center (ASMC).

Patient's Rights to Access Records

- **You have a right to request to see your records or to request a copy of your records.** Upon receipt of your written request, our Privacy Officer will contact you to make arrangements to review your records in the ASMC office to copy the records you have requested.
- **You have a right to request a written summary or explanation of your records.** Upon receipt of your request, our Privacy Officer will arrange for your physician to review and summarize your records.
- **You have a right to inspect and request an amendment of your records.** If, in reviewing your records, you find an inaccuracy in the facts documented or an omission, you have the right to submit an amendment to your record.
- **You have a right to request a limited accounting of disclosures of your records.** You may request an accounting of any of the disclosures of your health information to purposes other than treatment, payment, or healthcare administration.

Rights to Privacy

- **You may request additional protections for sensitive health information or to limit disclosures of portions of your health information.** In addition to the protections for highly confidential information specified in HIPAA, you may request, in writing, that other sensitive information be protected. Our Privacy Officer will take steps to implement these protections and to inform you of the limits of these steps.
- **You may designate a personal healthcare representative.** You may designate someone to act as your personal healthcare representative. This person would have the same rights of access as you, for health information. You may change your designated personal representative at any time.
- **You have a right to request that your personal health information be communicated to you in a different manner or at a different location.** You must make this request in writing.

Rights of Parents of Minor Children

As the parent of guardian of a minor child, you have the same rights of access to your child's records as to your own, with the following exceptions:

- Your rights to the access of the minor child's records have been revoked or limited by a court of law
- Your minor child is an emancipated minor under the law
- Services are provided to your child under the regulations of the State of Arizona

Your Responsibilities Under HIPAA

In order to safeguard your rights under HIPAA, you have a responsibility to keep ASMC informed of any changes that would affect the disclosure of your personal health information. You have an obligation to:

- Provide accurate information about your address, telephone number, and insurance coverage each time you visit.
- Report any changes in your personal health representative, emergency contact information, and structure of your family, etc.
- Respect the privacy rights of other patients.

Arizona Sports Medicine Center Responsibilities

Our first responsibility, as always, is to safeguard the health of our patients. If the provider believes any of the provisions of HIPAA could endanger your life or physical safety or that of another individual, the practice must act in accordance with this belief and do what is in the best interest of the patient.

We are also responsible for safeguarding your privacy. We have an obligation to keep you informed of any disclosures of your personal health information outside of those required for treatment, payment of services, and healthcare administration.

We also have an obligation to work with you to ensure your rights under HIPAA. Our Privacy Officer, with the support of all of the physicians and staff, will work directly with you to ensure your rights and privacy and to access under HIPAA.

Any patient believing his or her privacy rights have been violated may file a complaint with the Privacy Officer at ASMC or with the Secretary of Health and Human Services.

A complete copy of your privacy policy can be obtained at any of the reception areas in the Scottsdale, Tempe, or Gilbert offices, as well as, being posted on our web site. ASMC reserves the right to change the terms of this notice and to make the new terms apply to all protected health information it maintains.

Our Privacy Officer can be reached at 480-558-3744

Signature of Patient: _____ Date: _____

If the patient is an emancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

Signature of Personal Representative: _____ Description of Authority: _____ Date: _____



Gary L. Waslewski, MD
Douglas B. Freedberg, MD
Charles S. Peterson, MD
Erik J. Dean, DO
Amit A. Sahasrabudhe, MD

TO ALL PATIENTS:

If my account is over 120 days past due and I have not made a reasonable attempt to pay, a collection agency will be retained to collect payment for all monies due with an additional (35%) fee added to cover the cost of the collection agency and administrative costs. A (50%) fee will be added if legal costs are necessary.

Signature of Patient _____ Date _____

If the patient is an emancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

Signature of Personal Representative _____ Description of Authority _____ Date _____

We have implemented a new policy. You will be asked for a credit or debit card at the time of your check in, so that it can be scanned into your chart. The information will be held securely until your insurances have paid their portion of your charges and notified us of the amount you share. A statement will be sent letting you know the balance. Any remaining balance after 30 days will be charged to your card, unless payment arrangements have been made. This in no way will compromise your ability to dispute a charge or question your insurance companies determination of payment.

Co-payments are still due at the time of your visit. If you have any questions, please do not hesitate to ask.

Thank you for your cooperation,
Arizona Sports Medicine Center Staff

CREDIT CARD INFORMATION

VISA____ MASTERCARD____

Credit Card Number _____
Expiration Date _____
Cardholder's Name _____

For office use only: Patient account # _____

Caring for Athletes and Their Families
5111 North Scottsdale Rd., Suite 101 ■ Scottsdale, AZ 85250
20201 North Scottsdale Healthcare Dr., Suite 240 ■ Scottsdale, AZ 85255
3130 East Baseline Rd., Suite 101 ■ Mesa, AZ 85204

480.558.3744 Phone ■ 480.558.3801 Fax