

CENTRAL ARKANSAS SPORTS MEDICINE

DATE ____ / ____ / ____

◆ **PATIENT INFORMATION**

INJURY AREA _____

NAME _____ REFERRED BY _____

ADDRESS _____ SS # _____

CITY _____ STATE _____ ZIP _____ SEX M / F DOB ____ / ____ / ____

PHONE # HOME _____ CELL _____ MARITAL STATUS S / M / W / D

DRIVERS' LICENSE # _____ STATE _____ DATE OF INJURY/SURGERY ____ / ____ / ____

EMPLOYER _____ WORK PHONE _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY, CONTACT _____ PHONE _____

ADDRESS _____ RELATIONSHIP _____

◆ **RESPONSIBLE PARTY (IF MINOR)**

FATHER _____

MOTHER _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

DOB ____ / ____ / ____ SS# _____

DOB ____ / ____ / ____ SS# _____

DRIVERS' LICENSE # _____

DRIVERS' LICENSE # _____

EMPLOYER _____ PHONE _____

EMPLOYER _____ PHONE _____

◆ **PRIMARY INSURANCE**

INSURANCE CO _____

POLICY # _____

GROUP ID # _____

NAME OF SUBSCRIBER _____

RELATIONSHIP TO PATIENT _____

◆ **SECONDARY INSURANCE**

INSURANCE CO _____

POLICY # _____

GROUP ID # _____

NAME OF SUBSCRIBER _____

RELATIONSHIP TO PATIENT _____

◆ **MOTOR VEHICLE / WORKERS COMPENSATION ACCIDENTS**

If your injury occurred in a motor vehicle accident or while on the job and you are filing your medical bills with an attorney or a special workers' compensation provider, provide the following information:

INSURANCE COMPANY & CONTACT
OR ATTORNEY _____

WORKERS COMP COMPANY _____

ADDRESS _____

CONTACT _____

PHONE # _____

PHONE # _____

IDENTIFICATION # _____

◆ **FINANCIAL AGREEMENT**

As a courtesy, we attempt to verify insurance benefits for patients. This in no way guarantees that your insurance company will pay exactly as quoted, benefits cannot be guaranteed over the phone. This facility is not responsible for attaining or being aware of your policy requirement for referrals from your primary care physician, pre-certifications, or limits with your specific policy. Your insurance policy is a contract between you and your insurance company; therefore the responsibility lies with you, the patient, to be aware of this information. We will assist you if necessary to help you obtain this information. I understand I will be billed and agree to pay any co-pays, deductible, or balances unpaid by my insurance provider.

DATE _____

SIGNATURE OF PATIENT OR GUARDIAN (IF MINOR)

Central Arkansas Sports Medicine, Inc., is not obligated to withhold statements or to wait until settlement has been made before receiving payment for services.

◆ **STUDENT ATHLETE INFORMATION**

If you participate in an athletic activity at your school and your injury occurred during a practice or a game, provide the following information:

PATIENT NAME _____

NAME OF SCHOOL _____ GRADE _____

SPORT: FOOTBALL GIRLS BASKETBALL BOYS BASKETBALL BASEBALL FAST-PITCH SOFTBALL VOLLEYBALL CHEERLEADER
 TRACK CROSS COUNTRY GIRLS SOCCER BOYS SOCCER SWIM TEAM TENNIS GOLF BOWLING DANCE TEAM

COACH _____

INJURY _____

DATE OF INJURY _____

HOW DID INJURY OCCUR? _____

NORTH LITTLE ROCK SCHOOL DISTRICT STUDENT ATHLETES ---

HAS A SCHOOL INSURANCE FORM BEEN COMPLETED AND FILED? YES _____ NO _____ (COACH HAS FORMS)

CENTRAL ARKANSAS SPORTS MEDICINE

Patient Name: _____ Date: _____

Are you presently working? YES NO Date of next physician visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had these symptoms before? YES NO

Check which apply to your symptoms:

- | | | |
|---|---|--|
| <input type="checkbox"/> work related injury | <input type="checkbox"/> recurrence of previous injury | <input type="checkbox"/> injury related to falling |
| <input type="checkbox"/> motor vehicle accident | <input type="checkbox"/> injury related to lifting | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> cause unknown | <input type="checkbox"/> athletic / recreational injury | |

Have you had a related surgery? YES NO

Do you have, or have you had any of the following?

	YES	NO		YES	NO
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/ Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel/Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / CVA	<input type="checkbox"/>	<input type="checkbox"/>

If yes on any of the above, please briefly explain and give approximated date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking any medication? YES NO

PAIN SCALE

Using the symbols below, please mark the areas you are having discomfort:

Aching

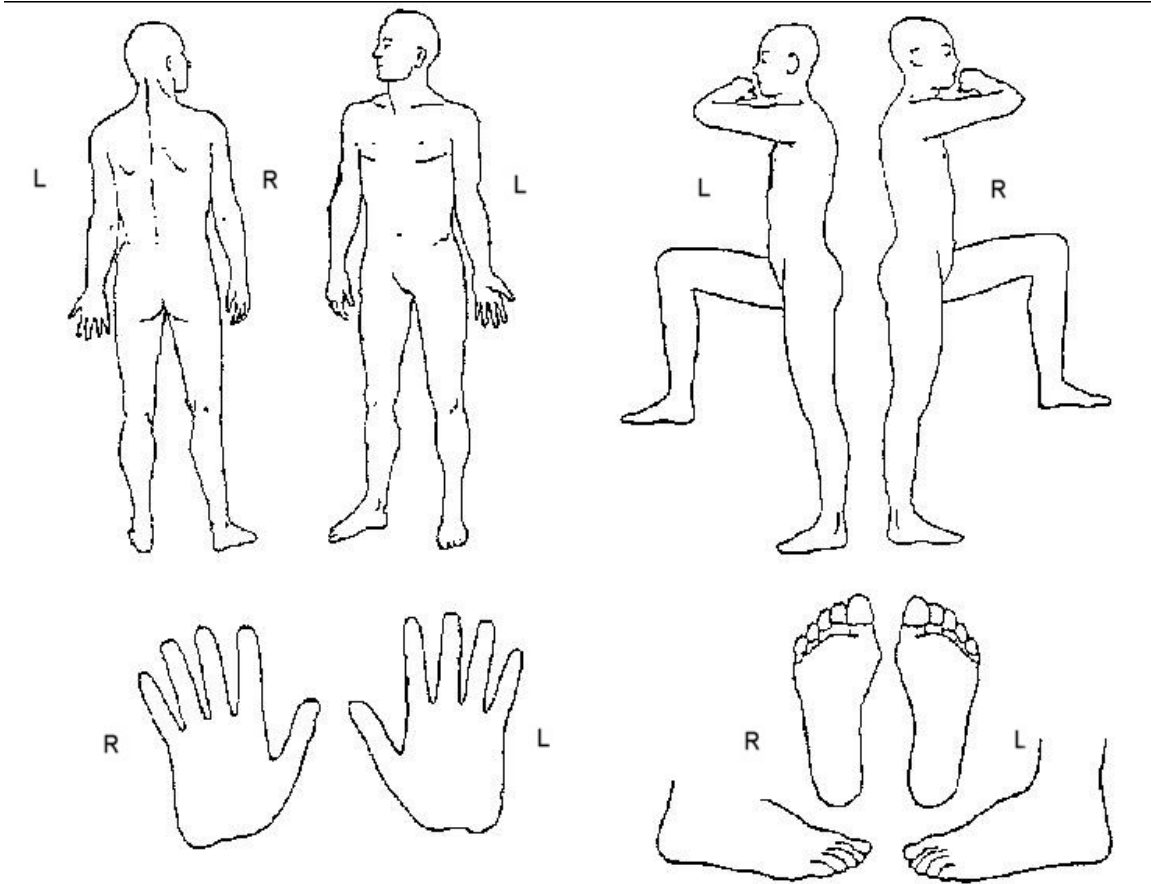
xxxxxx

Burning

//////////

Numbness

00000000



Please rate your pain using the following scale:

0 1 2 3 4 5 6 7 8 9 10

No
Pain

Mild
Pain

Moderate
Pain

Distressed
Pain

Severe
Pain

Very Severe
Pain

Excruciating
Pain

CENTRAL ARKANSAS SPORTS MEDICINE

PATIENT RIGHTS ON PROTECTED HEALTH CARE INFORMATION

I consent to the use or disclosure of my protected health information by Central Arkansas Sports Medicine for the purposes of diagnosis or providing treatment to me, obtaining payment or to conduct health care operations of Central Arkansas Sports Medicine. I understand that diagnosis or treatment of me by Central Arkansas Sports Medicine may be conditioned upon my consent as evidenced by my signature on this form.

1. I have the right to request a restriction on how my information may be used or disclosed to carry out treatment, payment, or health care operations of the practice.
2. I have the right to revoke this consent in writing at any time, except to the reliance Central Arkansas Sports Medicine may have upon my information.
3. My protected health information includes my demographic information, collected from me and created or received by my physician, other health care provider, my insurance, employer or a health care clearinghouse.
4. I have the right to review Central Arkansas Sports Medicine's **Notice of Privacy Practices** prior to signing this document.
5. I understand the **Notice of Privacy Practices** describes the types of uses and disclosures of private health care information and describes my rights and Central Arkansas Sports Medicine's duties with respect to my protected health care information.
6. Central Arkansas Sports Medicine reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by requesting a revised copy.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

I understand Central Arkansas Sports Medicine may rely on the use or disclosure of my protected health care information to be used to carry out treatment, payment, or related health care operations.

I understand my protected health care information will no longer be protected by federal or state law if I authorize its release.

I understand I have the right to revoke this authorization. I may also request access of my protected health information. I understand my request must be in writing and sent to the office of *Central Arkansas Sports Medicine, 2400 Crestwood, Suite 107, North Little Rock, Arkansas 72116*.

I authorize Central Arkansas Sports Medicine to release my protected health information for purposes of treatment.

I do not authorize Central Arkansas Sports Medicine to release my protected health information.

SIGNATURE OF PATIENT OR GUARDIAN (IF MINOR)

PRINT NAME OF PATIENT OR GUARDIAN (IF MINOR)

DATE

DESCRIPTION OF GUARDIAN'S AUTHORITY (IF MINOR)

MEDICAL RELEASE / CONSENT TO TREATMENT

I request and authorize my insurance company(s) or Medicare to pay directly to Central Arkansas Sports Medicine, Inc., any proceeds payable under the terms of my policy(s). This is an irrevocable assignment; I understand and agree any unpaid balance not covered by this policy is my obligation and will be paid by me.

I grant Central Arkansas Sports Medicine consent to release medical information to my insurance company(s) or my lawyer. I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital, and physical therapy pre-certifications, deductibles, co-insurance, and co-payment.

I hereby authorize and consent to treatment rendered by Central Arkansas Sports Medicine as suggested by my physician or upon my own self-referral.

SIGNATURE OF PATIENT OR GUARDIAN (IF MINOR)

PRINT NAME OF PATIENT OR GUARDIAN (IF MINOR)

DATE

DESCRIPTION OF GUARDIAN'S AUTHORITY (IF MINOR)

It is the policy of Central Arkansas Sports Medicine, Inc., to help the patient in obtaining full benefits from his/her insurance company. However, we are not obligated to withhold our statements or to wait until settlement has been made before receiving payment for our services.