THE CENTER FOR HEALTH & SPORTS MEDICINE

NEW PATIENT REGISTRATION INFORMATION

Date_____

Would you like to receive access to your record by: **Portal or Mail**
Please circle

PATIENT INFORMATION

Name_*Last*_____*First*_____*Middle*__
Preferred Name_____ **DOB**_____

Address__*Street*_____*City, State, Zip*____
_____

Home Phone_____
Cell Phone_____
Work_____

Email _____ **Sex** _____
Orientation _____ **SSN**_____

Marital status_____
Employment_*Occupation Title*_____*Employer*_____
_*Emplover Phone #*___

Language_____
Race_____
Ethnicity_____
Guardian Name_____
Next of Kin_*Name*_____*Relationship*_____*Phone #*__

EMERGENCY CONTACT INFORMATION

Contact Name_____
Relationship_____

Address__*Street*_____*City, State, Zip*_____
_____

Home Phone_____
Cell_____
Email _____

INSURANCE INFORMATION

Primary Ins. Name_____
ID#_____

Name on Policy_____
Group#_____

Subscriber _____
DOB_____ **SSN**_____

Secondary Ins. Name _____
ID#_____

Name on Policy _____
Group#_____

Subscriber Name_____
DOB_____ **SSN**_____

Person responsible for bill _____

Guarantor__*Name*_____*Relationship to Patient*_____
_*Date of Birth*_____

Address__*Street*_____*City, State, Zip*_____
_____

Phone_____
Email_____ **SSN**_____

How were you referred to our practice?

_____

- *By signing below you agree that the above information is all correct and valid. You also agree to provide our practice with verified and up-to-date insurance information at the time of arrival for each appointment, and that if there are any changes to your current policy, you will provide us with the updated information within 45 days. Otherwise, you will be obligated to pay in full any remaining balance.*

Signature: _____ ***Date:*** _____

Patient History

Medical History – *Please mark any previously treated conditions you may have or have had in the past.*

- □ Heart Disease
- □ High Blood Pressure
- □ Diabetes
- □ Anxiety/Depression
- □ Skin Disorder
- □ Other _____
- □ Cancer
- □ High Cholesterol
- □ Thyroid Disorder
- □ Gastrointestinal
- □ Organ Disorder

□ **NONE**

Social History – *Please circle those that apply.*

Smoking – Never Yes Quit – When _____

Daily amount _____ Years of use _____

Exercise – None Some Regular Heavy

Type(s) _____ Duration _____ Times/Week___

Alcohol – None Some Regular Heavy

Caffeine – None Some Regular Heavy

Diet – Regular Other_____

Married Yes No Sexual Orientation _____

Employed – Yes No Occupation_____

Hobbies/Activities _____

Surgical History – *Please list any surgeries or procedures received under general anesthesia.*

Surgery Type Date

_____ _____

_____ _____

Medications – *Please list any medications you are currently taking on a routine basis. If not enough space, please provide an attached list of all your medications or surgeries – Thank you.*

Name Dosage Frequency

_____ _____

_____ _____

_____ _____

Do you need refills today? ___ Yes ___ No

Allergies – *Please list any drug or latex allergies you may have.*

_____

Family History – *Please list any medical complications that may exist among your immediate family members.*

_____

_____

Review of Systems

Please circle any of the symptoms you are having at this time.

Constitutional

Fever Night Sweats Exercise Intolerance

Weight Gain ____ lbs Weight Loss ____ lbs

Head, Eyes, Ears, Nose, Mouth, or Throat

Eye: Dry Eyes Irritation Vision Change

Ear: Difficulty Hearing Ear Pain

Nose: Frequent Nosebleeds Nose/Sinus Problems

Throat: Sore Throat Snoring Dryness or Mouth Breathing

Mouth: Mouth Ulcers Oral/Teeth Problems Bleeding Gums

Cardiovascular

Chest Pain Arm Pain with Exertion Known Heart Murmur

Palpitations Shortness of Breath with Exercise or Lying Down

Respiratory

Cough Wheezing Shortness of Breath Sleep Apnea

Gastrointestinal

Abdominal Pain Vomiting Change in Appetite Diarrhea

Blood in Vomit Painful Digestion GERD Black/Tarry Stool

Urinary/Genital

Loss of Urinary Control Difficulty Urinating Blood in Urine

Increased Frequency of Urination Incomplete Emptying

Burning Sensation

Musculoskeletal

Muscle Aches Muscle Weakness Joint Pain Back Pain

Swelling of the Extremities/Hands/Feet

Skin

Abnormal Mole Yellowing of Skin Rash Redness of Skin

Skin turning Blue Itching Dry Skin Growth/Lesion

Endocrine/Hormonal

Fatigue Hair Loss or Growth Increased Thirst Cold Intolerance

Hematologic/Lymphatic

Swollen Glands Bruising Excessive Bleeding

Allergic/Immunologic

Runny Nose Sinus Pressure Itching Hives Sneezing

Neurologic

Loss of Consciousness Weakness Numbness/Tingling Seizures

Dizziness Headaches Migraines Restless Legs

Psychiatric

Depression Disturbed/Restless Sleep Substance Abuse

Feeling Unsafe in Relationship

Other Symptoms _____

_____ _____

THE CENTER FOR HEALTH & SPORTS MEDICINE

Financial Assignment and Release

We're committed to providing our patients the best possible care, and we are pleased to discuss our professional fees. Our fees are set in accordance to a customary and reasonable rate, except for contractual arrangements with individual insurance companies. Please ask us if you have any questions about our fees, financial policies, or your patient responsibility.

Please understand, your insurance policy is a contract between you and your insurance company. It is your responsibility to know the terms of your insurance policy.

All new patients will be asked to provide payment information prior to being seen by our providers. We also ask you to provide a picture identification and insurance card which will become a permanent part of your chart.

By signing this form, you give consent to be billed for recommended services performed that are not covered under the terms of your insurance plan. Medicare patients will also be provided a separate Advance Beneficiary Notice ("ABN") form to sign for non-covered services. Acceptable payment forms are cash, check and most major credit cards.

Please read and initial below:

____ I hereby assign my insurance benefits to be paid directly to the physician. I hereby authorize Center for Health & Sports Medicine, LLC to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance.

____ If covered by Medicare, CHAMPUS, or any of our managed plans, we will file your insurance claim.

____ I am responsible for any copayment, coinsurance, deductible, or non-covered services at the time of my visit

____ If Center for Health & Sports Medicine, LLC does not participate with my insurance, I will be responsible for full payment at the time of my visit.

____ All uninsured/self-pay patients are expected to pay for services in full at the time services are rendered.

____ In the event my insurance company does not pay the full balance within 45 days, Center for Health & Sports Medicine, LLC will notify me so that I may contact my insurance company for payment prior to being billed.

____ I remember that ultimately, financial payment responsibility rests with the patient.

____ Patients are ultimately responsible for knowing what their insurance covers with respect to the type of visit and services requested.

____ It is my responsibility to advise the office of any change in my insurance or my contact information.

____ Should it ever become necessary for Center for Health & Sports Medicine, LLC to use the services of a collection agency to collect my account, I agree to pay the collection agency's fee (based on a percentage of my account balance, the current percentage is ___%) and all costs of collection, including a reasonable attorney's fee.

____ In the event that I receive a check directly from my insurance company payable to me for services rendered by Center for Health & Sports Medicine, LLC, I understand that this payment belongs to Center for Health & Sports Medicine, LLC.

I agree to endorse the back of the check as shown below and promptly deliver the check to Center for Health & Sports Medicine, LLC.

Pay to the order of Center for Health & Sports Medicine, LLC

_____

My signature

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature_____

Printed Name _____

Date _____

THE CENTER FOR HEALTH & SPORTS MEDICINE

Health Care Status Authorization/Privacy Release

I, _____ (name of patient), hereby give authorization to The Center for Health and Sports Medicine for the release of information concerning the status of my health care, including results of laboratory and radiology tests, and to discuss my plan of treatment with

_____ _____

Name of Authorized Individual Relationship to Patient

I understand that I may revoke this authorization at any time.

_____ _____

Patient Signature & Date Witness & Date

AUTHORIZATION FOR USE OF ANSWERING MACHINES

I, _____ (name), authorize The Center for Health and Sports Medicine to provide detailed information to me via my home and/or work answering machine or cell voicemail concerning my appointments, referrals, and test information. The practice will not leave medical information on a voicemail/answering machine that does not specifically identify my name. I also understand I am responsible for the privacy and security of the number where the message may be left.

I understand that I may revoke this authorization at any time.

_____

Patient (Parent) Signature & Date

THE CENTER FOR HEALTH & SPORTS MEDICINE

Financial Policy

We would like to thank you for choosing The Center for Health & Sports Medicine for your medical care. As a patient, we would like to inform you of our current office and financial policies. As a patient, it is your responsibility to know and understand the extent of coverage provided by your insurance. While we are sympathetic to the costs of medical care, our primary concern is to provide you with appropriate medical care independent of cost. The following are our policies:

-Payment is required at the time of service. We accept cash, check and most major credit cards.

-For patients without insurance, full payment is required at the time of service. In accordance with our agreements with insurance companies, our rates are based on the current Medicare fee schedule for each of the services rendered.

-For patients with **HMO** plans, co-payment is required at the time of service. The amount of co-payment varies with different plans. You are responsible for knowing the co-payment and primary care physician listed on each insurance card.

-For patients with **PPO** plans, payment is required at the time of service until your yearly deductible has been met. After that, we require co-payments or your liability to be paid at the time of service.

-It is your responsibility to understand your insurance benefits and what services are covered. While the filing of insurance claims is a courtesy we extend to our patients, all charges not covered by your insurance by your insurance company are your responsibility.

We understand the confusing nature of insurance and will be happy to lend assistance in understanding the bills related to your medical care at our office. Our fees are dictated by the contracts we have signed with insurance companies, as are the services covered in the office. We would recommend you clarify any questions you might have with your insurance provider prior to your appointment.

I have read the above Financial Policy, I have understood it, and I agree to it. A copy of this financial policy is available upon request.

Patient's Signature_____

Print Name_____

Date_____

THE CENTER FOR HEALTH & SPORTS MEDICINE

Missed Appointment Policy

When we make an appointment for you, we are reserving a room and resources for your particular needs. We ask that if you must change or cancel an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to accommodate our other patients in a timely manner.

If you miss your appointment, or you are more than 15 minutes late you will be charged a 'No Show' fee of $60 ($30 for Physical Therapy appointments).

These charges are not submitted to, nor covered by, insurance, and therefore become your responsibility. All No Show fees must be paid before a new appointment can be scheduled.

Repeated missed appointments may result in the loss of future appointment privileges.

Our office offers email and text message reminders for all our patients. These are sent to the email and cell phone you have on file with our office. While you can choose to opt out of receiving these reminders, you are still held responsible for making and keeping your appointments.

We value you as a patient and look forward to providing for your healthcare needs in the future. Please let us know any questions you have regarding this or any of our office policies, as it is our goal to provide you and all of our patients with the best possible patient experience.

Print Name: _____

Signature: _____

Date: _____

Cell phone: _____

Email Address: _____

THE CENTER FOR HEALTH & SPORTS MEDICINE

Workers' Compensation

Workers' Compensation patients will be seen only after proper authorization and paperwork has been received.

UNACCOMPANIED MINORS

The parents (or Guardian) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

COMPLETION OF FORMS

The Center for Health and Sports Medicine reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave Forms.

I hereby authorize The Center for Health and Sports Medicine to bill my insurance directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release the Social Security Administration or Intermediaries any information needed for this related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the insurance information is currently correct.

_____

Responsible Party Signature *Patient Name (printed)* *DOB* *Date*

NOTICE OF PRIVACY PRACTIES (NPP)

I acknowledge receipt of a copy of The Center for Health and Sports Medicine Notice of Privacy Practices wither at this time or previously. By accepting services at The Center for Health and Sports Medicine, I authorize them to use and disclose information from and release copies of my patient medical records in accordance with their policies and privacy practices, which are summarized in the NNP, including disclosure of my patient past, present and future healthcare providers.

_____

Patients Signature (Guardian)

Methods of payment: Cash, Check, Debit and Credit Cards.

RECORD REQUEST OR RECORD RELEASE

Records should be sent to: Dr. Ross Osborn

The Center for Health and Sports Medicine

115 Bartram Oaks Walk, Suite 104

St Johns, Florida 32259

Phone: 904-240-0442 Fax: 904-240-0471

Records to be released from: _____

_____

_____

_____

Clinical notes from_____

Lab results_____ Imaging_____

As part of the medical record, the following information will be released unless stricken. Sexual abuse information, drug & alcohol abuse information, child abuse & neglect information, psychiatric information and AIDS/HIV information.

I have carefully read this consent, understand its contents and authorize the release of the above specified information. I understand that this authorization will remain in effect for one year, but I may revoke it at any time in writing. I further understand that such revocation will not apply to any information already released under this authorization. I understand that I am under no obligation to sign this authorization and that my ability to obtain treatment from The Center for Health and Sports Medicine will not depend in any way on whether I sign this authorization. I understand that I have a right to receive a copy of this authorization.

I understand that State and Federal Law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, but that The Center for Health and Sports Medicine has no control over the recipient and cannot therefore guarantee that the recipient will not disclose such information. I hereby release The Center for Health and Sports Medicine from any and all liability to their reliance upon this authorization or release of information pursuant to this authorization.

Signed_____ Date_____

Patient Name_____ DOB_____

Witness_____ Date_____

IF THE PATIENT IS UNABLE TO SIGN DUE TO MENTAL OR PHYSICIAL DISABILITY OR IS A MINOR, AUTHORIZATION MUST BE SIGNED BY THE LEGAL GUARDIAN