THE CENTER FOR HEALTH & SPORTS MEDICINE

New Patient Registration

Welcome to the Center for Health and Sports Medicine. In preparation for your first appointment, we ask that you bring your insurance card, a picture ID, and a method of payment. Additionally, we ask that you bring a list of medications, surgeries, and other physicians you have seen.

Patient Information

Name
First Name
Last Name
Preferred Name
Title
Date of Birth

Address
Street
City
State/Zip Code

Contact Information
☐ Primary Phone
☐ Work Phone
☐ Alternative number
☐ Email address
Please check preferred contact above

Demographics
Marital Status
Occupation
Employer
Employer phone
Ethnicity (optional)
Race (optional)
Guardian (if applicable)

How did you hear about our practice?

☐ Word of Mouth
☐ Web search
☐ Outlaws Football
☐ Social Media
☐ Family Member
☐ Bartram Trail HS
☐ Creeks Lacrosse
☐ Other
☐ Insurance Company
☐ Creekside HS
☐ Physician Referral

By signing below, you agree that the above information is correct and valid and agree to provide our practice with verified and up-to-date insurance information at the time of arrival for each appointment. It is your responsibility to update us on any changes to your current policy, your contact information, or change in medical status.

Signature/Date _____

Printed Name _____

Financial Responsibilities, Assignment and Release

Fruit Cove
201 Village Oak Drive
Fruit Cove, FL 32259
Phone (904) 240-0442
Fax (904) 240-0471

St Augustine
4255 US1 South, Unit 10
St Augustine, FL 32086
Phone (904) 240-0565
Fax (904) 240-0471

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As a patient, we would like to inform you of our current financial policies and responsibilities.
All new patients will be asked to provide payment information prior to being seen. We also ask that you provide a copy of your insurance card and a photo ID, which will become a part of your medical record.
Our commitment is to provide you with the most appropriate medical care. While we understand cost may be a consideration in the overall care of our patients, we make decisions based on the best care available. We are happy to discuss and provide you with a list of our professional fees, which are set in accordance with reasonable and customary rates. We are also happy to discuss and explain your medical bill in relation to contractual arrangements with your insurance company, so that you may have a complete understanding of fees and payment.
In the event your insurance does not pay the full balance within 45 days (about 1 and a half months) of the date of service, the Center for Health and Sports Medicine will notify you so that you may contact your insurance company for payment prior to being billed.

Please read and check each item below:

☐ It is your responsibility to know and understand the coverage and terms provided by your insurance contract. Services provided by our office which are not covered by your insurance become your responsibility.
☐ I hereby assign my insurance benefits to be paid directly to the Center for Health and Sports Medicine. I authorize the Center for Health and Sports Medicine to release medical information necessary to obtain payment.
☐ I understand I am financially responsible for all charges not covered by my insurance, which include copayments, coinsurance, and/or deductibles, and these fees are due at the time of service.
☐ All uninsured, patients with non-participating insurance, or self-paying patients are expected to pay for services in full at the time services are rendered.
☐ It is my responsibility to notify the Center for Health and Sports Medicine of any change in my insurance information or other billing demographic information.
☐ The parents (or Guardian) of unaccompanied minors will be responsible for full payment of fees, unless covered by a participating managed plan.
☐ If it becomes necessary for the Center for Health and Sports Medicine to use a collection agency to collect unpaid balances, I agree to pay the agency's fees and all costs of collection, including any attorney fees that may be incurred.
☐ If I receive a check directly from my insurance company for services rendered by the Center for Health and Sports Medicine, I understand that this payment belongs to the Center for Health and Sports Medicine and will endorse the payment to them.
☐ If your insurance is Medicare, CHAMPUS, or any managed plan we accept, we will file your insurance claim.

By signing below, you authorize The Center for Health and Sports Medicine to bill your insurance for services provided, authorize any holder of information a release from the Social Security Administration or intermediaries, any information necessary for these claims. I permit a copy of this authorization to be used in place of the original. This also serves as consent to be billed for recommended services performed that are not under the terms of your insurance plan. Medicare patients will be asked to sign a separate Advanced Beneficiary Notice (ABN) prior to delivering non-covered services.

Person responsible for payment

Guarantor Name	Street Address
Relationship to Patient	City
Date of Birth	State
Email	Zip Code
SSN	Phone

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

Signature/Date _____

Printed Name _____

Health Care Status Authorization, Privacy Release and Emergency Contact Information

____ I give authorization to the Center for Health and Sports Medicine to release information concerning the status of my health care, including results of labs, radiology tests and treatment plans and other pertinent medical information to the following person(s):

Name/Relationship to Patient _____

Phone number/Address/Email _____

____ Check here if this person is your emergency contact

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

Signature/Date _____ Printed Name. _____

Witness/Date _____ Printed Name. _____

Authorization for contact

We use the methods below to collect information and communicate with you regarding your appointments, office closures and events, preventative health reminders, test results and obtaining medical history, including medications and vaccines.
With your consent below, we will communicate with you by the following means:

___ Yes ___ No Receive texts
___ Yes ___ No Receive portal messages (email required)
___ Yes ___ No Medication history (accessed from pharmacy data)
___ Yes ___ No Receive calls (automated messages)
___ Yes ___ No Florida Shots (Florida database)
___ Yes ___ No Voicemails (only if patient identified)

I understand that I may revoke these authorizations at any time.

Signature/Date _____ Printed Name. _____

Missed Appointment Policy

When reserving an appointment for you, we are allocating a room and resources for your visit. We ask that if you must change or cancel an appointment you give us at least 24 hours' notice. This courtesy makes it possible to accommodate the needs of our other patients in a timely manner.
If you miss an appointment, including being late more than 15 minutes, you will be charged a "Missed Appointment" fee. These fees are $60 for a medical appointment, $30 dollars for a physical therapy appointment and $10 for a laboratory appointment.
These charges are not submitted to, nor covered by insurance, and therefore become your responsibility. The amounts are intended to offset the cost of allocating resources to your appointment. Repeated missed appointments may result in the loss of future appointment privileges.
We offer email and text reminders that can be sent to your email and cell phone on file. While you can opt out of these, you are still responsible for knowing when your appointment is and keeping it.
Please let us know if you have any questions regarding this policy, as it is our goal to provide you and all our patients with the best possible medical care.

Signature/Date _____

Printed Name _____

Notice of Privacy Practices

The Center for Health and Sports Medicine is happy to provide you with a copy of a Notice of Privacy Practices in accordance with state and federal regulations. We can provide you with a written copy upon request. By accepting services at The Center for Health and Sports Medicine, you are authorizing us to use and disclose information from and release copies of my patient medical records in accordance with these practices and policies.

Signature/Date _____

Printed Name _____

Release of Medical Records

Records to be released from:

Name of doctor/practice _____

Address _____

City/State _____

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Phone Number _____

Please release the following:

Clinical notes _____ Lab Results. _____. Imaging Results _____

From the following dates: From _____ To _____

I have carefully read this consent, understood its contents and authorize the release of the above specified information. I understand that this authorization will remain in effect as a patient at the Center for Health and Sports Medicine but may be revoked by written request at any time. Revocation does not apply to information already released to us.

I understand I am under no obligation to sign this authorization, and I have a right to receive a copy at any time.

I understand State and Federal Law may prohibit the recipient from re-disclosing information provided pursuant to this authorization, but the Center for Health and Sports Medicine has no control over the recipient and cannot therefore guarantee 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.

Signature/Date _____

Printed Name _____

Date of Birth _____

Witness signature/Date _____

Printed Name _____

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