OS1 SPORTS INJURY CLINIC — PATIENT REGISTRATION

PATIENT INFORMATION — UPON COMPLETION OF THIS FORM YOU MAY EMAIL IT TO info@bettersooner.com

Legal name:_____ Preferred Name:_____ Previous Name: _____
LAST FIRST MIDDLE INITIAL

DOB: | Sex: | Married or Single:

Home phone: | Cell phone: | Other:

Social Security Number: | Email:

Address:

Emergency Contact: _____ _____ _____
NAME PHONE NUMBER RELATIONSHIP TO PATIENT

Preferred Pharmacy: | Pharmacy address or phone number:

INSURANCE INFORMATION

PRIMARY	SECONDARY (if applicable)
Insurance Name: _____	Insurance Name: _____
Are you the primary subscriber? YES_____NO _____	Are you the primary subscriber? YES_____NO _____
IF NO: Name of Primary Subscriber: _____	IF NO: Name of Primary Subscriber: _____
DOB:_____Social:_____	DOB:_____Social:_____
Address (if different):_____	Address (if different):_____
Phone number: _____	Phone number: _____
Relationship to patient: _____	Relationship to patient: _____

How did you hear about us?

Is this a worker's compensation injury? YES☐ NO☐ If yes, please see front desk

1. ***Consent for Treatment-*** I consent to necessary treatment, including drugs, predication, performance and operation of X-ray, or other studies that may be used by the physician, nurse, or staff.
2. ***Consent for E-Prescribing-*** I have been made aware and understand that the medical practices and offices may use an electric prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.
3. ***Insurance-*** I understand this office participates in most insurance plans, including Medicare. I acknowledge that if I am not insured by a plan that this office does business with, that payment in full is expected at each visit. I agree to provide to provide this office with my current insurance information. If I am insured with a plan that this office does business with, I will need to have a current card so that my coverage can be verified. There may be certain routine services performed during your visit(s), such as ultrasounds, X-rays, MRI, lab work, injections and/or other testing we feel is necessary for your treatment but may not be covered by your insurance contract. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage. By signing below, I agree that I will be responsible for costs not covered by insurance and for any costs not paid for by my insurance company, whether or not said costs are covered by my insurance contract.
4. ***Co-payments and Deductibles-*** I acknowledge that all co-payments and deductibles must be paid at the time of service, as required by my contract with my insurance company.
5. ***Cancellation/No-Show Policy-*** I understand and acknowledge that if I do not call to cancel an appointment, I may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and the office is unable to schedule me for a visit due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance I agree to pay a $25 fee; this will not be covered by your insurance company. If I am 15 minutes or more late for my scheduled appointment, I may be considered to have canceled my appointment without notice.
6. ***Notice of Privacy Practices-*** I acknowledge that I received a copy of the notice of Privacy Practices.

SIGNATURE:_____ **DATE:**_____

**Entering your name in this field constitutes a digital signature*

OS1 SPORTS INJURY CLINIC

Health Information

Patient Information & Profile

Name (Last, First, Middle)	Date of Birth:	Chief Complaint- Why are you here today?
If this was an injury, please explain the incident:		Date of accident/injury/start of pain?
Describe your symptoms (sharp, burning, dull, aching, etc.)		
What makes your condition worse?	What makes your condition better?	
How often do your symptoms occur? (constantly, rarely, intermittently, etc.)		
Have you been treated for these symptoms before? (Physical therapy, surgery, etc.)	Referring Physician:	

Medications/Pharmacy

Please list all medications including, vitamins and over-the-counter drugs, you are currently taking. (Include Name, Strength, and Frequency)

_____

_____

_____

_____

Medical History

Please check any of the following that apply to you

- ☐ Fever
- ☐ Lightheadedness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Congestion
- ☐ Cough
- ☐ Itching/Rash
- ☐ Blurry Vision
- ☐ Corrective lens
- ☐ Decreased Hearing
- ☐ Decreased sense of smell
- ☐ Difficulty swallowing
- ☐ Chest Pain
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Congenital heart problems
- ☐ Dizziness
- ☐ Heart murmur
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea
- ☐ Memory Loss
- ☐ Seizures
- ☐ Strokes
- ☐ Numbness/Tingling
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping

Other: _____

Do you drink? _____
If yes, how often? _____

Do you smoke? _____
If yes, how often? _____

Height: _____

Weight: _____

Please list any current health history we should be aware of (cancer, hypertension, diabetes, etc.)

_____
_____
_____

Allergies:

_____
_____
_____

Surgical History (Please list type of surgery and date)

_____
_____
_____
_____

Please list any family medical history

Father: _____
Mother: _____

_____
Print Patient Name

_____ _____
Patient/Guardian Signature Date

**Entering your name in this field constitutes a digital signature*

OS1 Sports Injury Clinic
1031 Brocks Gap Parkway, Suite 185
Hoover, Alabama 35244
(205) 352-2911
www.bettersooner.com

Authorization to Disclose Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

At OrthoSports1st, P.C. d/b/a OS1 Sports Injury Clinic ("OS1"), as described in the Notice of Privacy Practices, it is our policy to not release confidential health information except as specifically permitted (or required) by Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (for example, for treatment, payment, and operations) or in accordance with a patient's authorization. **Please refer to the Notice of Privacy Practices for more information**.

If you would like to authorize OS1 to release your protected health information (PHI) beyond what is already specifically permitted by HIPAA, please indicate the PHI you authorize to disclose and the individual(s) or organization(s), or class of individual(s) (e.g., coach or athletic trainers at my school) to whom you authorize OS1 to release such PHI:

➔ **The disclosure will be made to the following** (list the names or describe the class of individual(s)/organization(s)):

Name/Class: _____ Name/Class: _____

Phone No.: _____ Phone No.: _____

Relationship: _____ Relationship: _____

➔ **Dates for medical records to be disclosed** (list dates or range): _____

➔ **The type and amount of information to be used or disclosed** (select *Entire* record or the specific *Portion(s)* of your record):

☐ **Entire Medical Record** including, but not limited to, records sensitive in nature relating to psychiatric treatment. (If this box is checked, this authorization applies to your *entire* medical record, regardless of what you check below.)

***OR*:**

☐ **Only the following specific Portion(s) of my Medical Record** (indicate portion(s) are to be disclosed):

- ☐ Patient Progress Notes and Intake Records
- ☐ History, Physical and Physician Progress Note
- ☐ Medication Records
- ☐ Operative/Procedure Reports
- ☐ Laboratory and Pathology Reports
- ☐ X-Ray and Imaging Reports
- ☐ Consultation Reports
- ☐ Other: _____

I hereby authorize the use or disclosure of information about the above-named patient, and I understand and agree that:

1. I may refuse to sign this authorization, and treatment or payment will not be conditioned on whether I sign this authorization.
2. I have the right to revoke this authorization at any time in writing delivered to the OS1 address listed above.
3. Any revocation will be effective only to the extent that action has not been taken in reliance on my prior authorization. Unless I revoke this authorization, it will expire in one (1) year.
4. The health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.
5. If OS1 has information relating to behavioral or mental health services, alcohol and drug treatment, sexually transmitted disease, AIDS, or HIV, this authorization would include such information unless I specifically indicate otherwise on this form.
6. Regardless of whether I sign this authorization, unless I specifically request a restriction on the information OS1 can use or disclose and OS1 agrees to such request, OS1 will still be permitted to use or disclose my protected health information as specifically permitted by HIPAA (for example, for treatment, payment, and operations).
7. I have received a copy of this authorization.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Relationship of Personal Representative to the Patient

If you have any questions or concerns, please contact OS1 Sports Injury Clinic's Privacy Officer:
Chip Vance | 1031 Brock Gap Parkway, Suite 185, Hoover, AL 35244 | (205) 352-2911 | chip@bettersooner.com