Scottsdale Sports Medicine Institute
Patient Information Sheet

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

MAILING ADDRESS_____ **APT** ____ **CITY**_____ **STATE**_____ **ZIP**_____

PHONE_____ **DOB**_____ **AGE**_____ **SS#**_____ **MARITAL STATUS**_____

ETHNICITY: HISPANIC____ **NON-HISPANIC**____ **(REQUIRED BY FEDERAL GOVERNMENT)**

RACE:_____ **I DECLINE TO LIST MY RACE:**_____ **(REQUIRED BY GOVERNMENT)**

PRIMARY LANGUAGE SPOKEN: ENGLISH:_____ **OTHER:**_____

EMPLOYER_____ **OCCUPATION**_____ **STUDENT**_____

WORK PHONE_____ **CELL PHONE**_____

EMAIL_____

EMERGENCY CONTACT_____ **CONTACT PHONE**_____

WHOM MAY WE THANK FOR THE REFERRAL?_____

RESPONSIBLE PARTY INFORMATION

WHO'S RESPONSIBLE FOR THIS VISIT? YOURSELF SPOUSE GUARANTOR PARENT **(PLEASE CIRCLE APPLICABLE ONE)**

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

RELATIONSHIP TO PATIENT_____ **DOB**_____ **SS#**_____

EMPLOYER_____ **OCCUPATION**_____ **PHONE NUMBER**_____

INSURED'S INFORMATION

NAME OF POLICY HOLDER_____ **DOB**_____ **SS#**_____

PRIMARY INSURANCE_____ HMO PPO ICA SELF PAY **EMPLOYER**_____

ID#_____ **GROUP#**_____ **INSURANCE COMPANY PHONE**_____

INSURANCE ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

DO YOU HAVE COPAY? YES NO **(PLEASE CIRCLE ONE) AMOUNT**_____ **EFFECTIVE DATES**_____

SECONDARY INSURANCE_____ HMO PPO ICA SELF PAY **POLICY HOLDER**_____

ID#_____ **GROUP#**_____ **INSURANCE COMPANY PHONE**_____

INSURANCEADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

IF THIS IS INDUSTRIAL, PLEASE PROVIDE THE FOLLOWING: DATE OF INJURY_____ **CARRIER**_____

CLAIM #_____ **CLAIMS ADJUSTOR**_____ **PHONE #**_____

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to Scottsdale Sports Medicine Institute. Authorization to release information: I hereby authorize Scottsdale Sports Medicine Institute to release all medical information needed to process this claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the above mentioned patient in the event that my insurance coverage does not pay. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services.

SIGNATURE OF PATIENT OF PATIENT OR PARENT IF MINOR_____ **DATE**_____

Medical Information Sheet

( ) ILLNESS ( ) INDUSTRIAL ( )ACCIDENT ( )AUTO ACCIDENT

Name_____Height_____Weight_____Age_____

Reason for being seen_____

Date of injury or onset of problem_____

Work related injury? Yes ( ) No ( )

Describe where and how accident or cause of injury occurred_____

_____

MEDICAL HISTORY

Primary Care Physician_____ GYN Physician_____

Are you ( ) left ( ) right handed?

Known allergies to medications (medicine/reaction)_____

Do you have an allergy to rubber or latex? ( ) yes ( ) no

Are you currently taking any medications? ( ) yes ( ) no If yes, please list name and dosages_____

Are you currently taking any supplements? ( ) yes ( ) no If yes, please list name and dosages_____

Long term use anticoagulants Long term use antibiotics Prolonged use of steroids Long term use high risk meds

Any previous surgeries? ( ) yes ( ) no If yes, please list procedure, date and complications, if any

_____

Any previous hospital admissions? ( ) yes ( ) no If yes, please list when and for what reason

_____

Do you take birth control? ( ) yes ( ) no
Do you have aspirin intolerance? ( ) yes ( ) no
Do you smoke? ( ) yes ( ) no
Any history of substance abuse? ( ) yes ( ) no
Do you drink alcoholic beverages? ( ) yes ( ) no

Do you have difficulties or problems with any of the following?

Heart	( )Y ( )N	Stroke	( )Y ( )N	Asthma	( )Y ( )N	Varicose Veins	( )Y ( )N
Diabetes	( )Y ( )N	Lungs	( )Y ( )N	Bowels	( )Y ( )N	Blood Pressure	( )Y ( )N
Stomach	( )Y ( )N	Liver	( )Y ( )N	Ulcers	( )Y ( )N	Blood Clots	( )Y ( )N
Kidneys	( )Y ( )N	Other	( )Y ( )N				

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE SERVICES

We expect that YOUR INSURANCE may not pay for the services described below. YOUR INSURANCE does not pay for all of your health care costs. YOUR INSURANCE only pays for what they determine to be covered items and services. The fact that YOUR INSURANCE may not pay for a particular item or service does not mean that you should not receive it; there is a reason your doctor recommended it. The following list includes, but is not limited to, services that may not be covered by YOUR INSURANCE:

Acupuncture	VO2 Max
Exercise Specialist	RMR Testing
Nutritionist	Manipulation
Supplements	Lab Draw (routine/hormonal)
Massage Therapy	Flu Shot
Vitamin Testing	Tetanus Shot
DEXA Body Comp	Pneumonia Shot

The purpose of this letter is to help you make an informed choice about whether or not you want to receive services from David G. Carfagno, D.O., Scottsdale Sports Medicine Institute, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain why YOUR INSURANCE probably will not pay
- Ask us how much these services will cost you (Estimated cost: $_____)

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE YOUR CHOICE

[ ] OPTION 1 YES. I want to receive services from David G. Carfagno, D.O., Scottsdale Sports Medicine Institute. I understand that my INSURANCE will not decide whether to pay unless I receive these services and a claim is submitted to them, I agree to be personally and fully responsible for payment at time of service while my INSURANCE is making its decision. If, my INSURANCE does pay, then you will refund to me any payment due to me. I also understand that my INSURANCE will notify me with an Explanation of Benefits (EOB) as to whether or not they have denied payment, or made payment.

[ ] OPTION 2 NO. I have decided NOT to receive services from David G. Carfagno, D.O., Scottsdale Sports Medicine Institute.

_____ _____

Signature of Patient or person acting on Patient's behalf Date

SCOTTSDALE SPORTS MEDICINE INSTITUTE, PLC

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent a threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

SCOTTSDALE SPORTS MEDICINE INSTITUTE, PLC

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree your request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician at 10133 N. 92nd St., #102, Scottsdale, AZ 85258.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practice manager at 10133 N. 92nd St., #102, Scottsdale, AZ 85258. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of the Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy right have been violated, you may file a complaint with our practices or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our practice manager at 10133 N. 92nd St., #102, Scottsdale, AZ 85258. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practices will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the practice manager at 10133 N. 92nd St., #102, Scottsdale, AZ 85258.

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

SCOTTSDALE SPORTS MEDICINE INSTITUTE, PLC
GENERAL INFORMED CONSENT

I hereby voluntarily give consent for:

Exercise Stress Test
VO2 Max/Anaerobic Threshold
Resting Metabolic Rate (RMR)
Massage Therapy
Osteopathic Manipulation (OMT)
DXA Body Comp/Bone Density
Joint/Soft Tissue Injections
Stretch Therapy
Exercise Consult
Pulmonary Function Test (PFT)

I understand that in addition to benefits, there are risks and potential side effects to the testing and/or treatment provided. The risks of the above include heart attack, fainting, abnormal heart rate and or blood pressure, muscle injury, fracture, nerve damage, skin damage, infection, dermatitis, bleeding, and death.

I understand that the test/treatment may require increasing effort and that at any time, I may terminate the test/treatment for any reason. I understand that during some tests/treatments, I may be encouraged to work at maximum effort and that at any time, I may terminate the test for any reason.

I understand every effort will be made to minimize problems by preliminary examination and observation during testing and treatment.

I understand that I am responsible for monitoring my own condition throughout the test/procedure, and should any unusual symptoms occur, I will cease my participation and inform the test/procedural administrator of the symptoms. Unusual symptoms include, but are not limited to: chest discomfort, nausea, difficulty breathing, and joint, skin or muscle injury.

Also, in consideration being allowed to participate in the fitness tests, I agree to assume all risks of such fitness testing, and hereby release and hold harmless _____, and their agents and contractors, from any and all health claims, suits, losses, or causes of action for damages, for injury or death, including claims for negligence, arising out of or related to my participation in the above aforementioned tests and/or treatments.

I have read the foregoing carefully and I understand its content. Any questions which may have occurred to me concerning this informed consent have been answered to my satisfaction.

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE

FINANCIAL AGREEMENT

My initials indicate that I have read and agree with each item below.

PATIENT NAME: _____

Professional Fees:

I agree to pay the following: (Special financial arrangements must be discussed at the first appointment with the OFFICE MANAGER only)

_____Any co-payment/co-insurance/deductible due at the time of service.
_____$25 processing fee for any returned check.
_____Collection/legal fees if account is referred to a 3rd party collection agency.
_____"SELF PAY" fees may include charges for other professional services such as

1. Report writing
2. Telephone conversations
3. Consulting with other professionals or family members
4. Preparation of records or treatment summaries
5. Legal proceedings, including preparation time and transportation
6. Above fees will be discussed in advance

Payment for Services:

_____It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or denied by my insurance plan.

_____I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

_____I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

_____I understand that, if after 90 days, my insurance company has not responded, I may receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

_____I understand that, if my account is referred to a collection specialist due to non-payment, I will pay any applicable collection fees.

_____I understand that if I do not pay any remaining balance within 30 days, I may be charged a $20.00 late payment fee. This fee will also be subject to and in addition to any collection fee charged by our 3rd party collection agency if it is necessary to refer my account to a 3rd party collection agency.

Policy for Missed Appointments and Cancellations:

_____I agree that I must give at least **24 hours notice** in advance to avoid a late cancellation or no show fee of $75.00.

I HAVE READ THIS FINANCIAL AGREEMENT, ASKED ANY QUESTIONS I HAVE ABOUT IT, AND AGREE TO ITS TERMS

_____
Patient or (Authorized Parent/Guardian Name) **Printed**

_____
Patient/Parent/Guardian signature Date

Scottsdale Sports Medicine Institute
Patient Information Sheet

Please print clearly

PATIENT INFORMATION:

LAST NAME_____ **FIRST NAME**_____ **MIDDLE**_____

We now offer EMAIL, phone, HOUSE CALLS and SKYPE services to better serve our patients. The cost of these services are not paid for by your insurance companies. If you would like to take advantage of any of the following services we will require that you leave a valid credit card number and authorization on file with our office. The cost of these services are as follows:

PHONE CALLS (After regular office hours or between 5pm-9pm):	**$ 50.00**
HOUSE CALLS (Within 10 miles)	**$200.00**
HOUSE CALLS (Greater than 10 miles)	**$300.00**

Authorization to charge credit card: I hereby authorize Scottsdale Sports Medicine Institute to charge the credit card listed below for the above described services. I hereby agree to pay for services rendered to the above mentioned patient as and when charges are incurred. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services.

NOT INTERESTED AT THIS TIME:_____

Type of credit card_____ **Credit Card Number**_____

Expiration Date:_____ **CCV code(on back of card)**_____

Name as it appears on the credit card:_____

Zip code:_____

SIGNATURE OF PATIENT OF PATIENT OR PARENT IF MINOR_____ **DATE**_____

SSMI Aesthetic and Metabolic Interest Questionnaire

Overall Health and Wellness Goals:

1.

2.

3.

Growing up did you eat at the table with your family or in front of TV or was it a lot of fast food dining out nights?

Do you shop for you food at the grocery store or do you eat out at restaurants mostly?

Previous Nutrition Programs Followed. Successful? Why or why not?

If you were to eat out, where would you go?

Your energy level is highest in the: morning / afternoon / evening (circle one)

Your largest meal is: breakfast / lunch / dinner (circle one)

Commitment level to reaching goals on a scale from 1-10? Why this number?

The day of the week you are busiest and cannot find the time or energy to work out is:

Where is your physical activity done? *Gym /Home /Park /Bicycle /Hiking trails /Pool*

What aesthetic concerns would you like to address? **Circle all that apply:**
Facial Lines / Wrinkles / Thin Lips / Length and Fullness of Eyelashes

Other than the services you are here for today, what additional services would you like to learn about?

- ☐ Metabolic Enhancement Program
- ☐ Personal Training
- ☐ BOTOX Cosmetic
- ☐ JUVEDERM XC injectable gel
- ☐ LATISSE (bimatoprost ophthalmic solution) 0.03%

☐ Approval to contact you

*Best phone number to reach you:

*E-mail:

☐ Approval to send you information on SSMI products and services (special offers)

☐ I'm not interested in any additional services at this time

Comprehensive Medical & Aesthetic Care for the Athlete
Scottsdale Sports Medicine Institute LLC
Ph. 480-664-4615 Fax 480-664-4367
www.scottsdalesportsmedicine.com
For medical advice and discounts on services, follow us on Facebook and Twitter