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

Acknowledgement of Receipt of Privacy Notice
Scottsdale Sports Medicine Institute, PLC

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature _____ Date _____

Printed Name if signed on behalf of the patient _____ Relationship (parent, legal guardian, personal representative, etc.) _____

EMAIL CONSENT FORM (OPTIONAL)

I do understand that by exchanging e-mails with Dr. David Carfagno along with my medical history that the e-mail site in which we will be exchanging e-mails is not a secured site.

Patient Name _____

Patient Signature _____ Date _____

E-mail Address _____

MEDICAL RECORD RELEASE (OPTIONAL)

I do hereby authorize SSMI to allow the following individuals to have access and discuss with Dr. Carfagno my personal medical records, medical history and all pertaining information.

Authorized Person (s) _____

Patient name _____

Patient Signature _____ 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.

Notice of Privacy:

We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.

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.