Scottsdale Sports Medicine Institute

PREVENTATIVE CARE

If you have had the following exams/tests/vaccines, please list the year and the doctor preformed the exams/tests

Physical Exam: _____

Colonoscopy: _____

EGD-Esophagogastroduodenoscopy _____

Prostate Exam (men only): _____

Pap Smear (women only):_____

Mammogram (women only):_____

Eye exam: _____

Dental exam: _____

Dermatology exam: _____

Flu Vaccine:_____

Tetanus Vaccine: _____

Pneumonia Vaccine:_____

Shingles Vaccine:_____

MMR Vaccine: _____

Varicella Or prior history of chicken pox: _____

Hep B Vaccine:_____

Chest X-rays:_____

Cardiac Stress Test: _____

Resting Echo: _____

AAA (Abdominal Aortic Aneurysm screening):_____

Carotid Ultrasound: _____

Bone Density:_____

Resting Metabolic Rate: _____

Body Composition Scan: _____

VO2max: _____

Medicare annual screening questions: _____

Patient Name: _____

Patient's Signature:_____

Date:_____

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 _____

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 _____

INSURANCE 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)

SECONDARY INSURANCE HMO PPO ICA SELF PAY POLICY HOLDER

ID# _____GROUP# _____INSURANCE COMPANY PHONE _____

INSURANCE ADDRESS_____ 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 payments of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for service 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 OR PATIENT/GUARDIAN IF MINOR_____ DATE _____

Give us an opportunity to Thank the one who referred you to us and gave us the chance to help you.

Please share your source with us below:

Facebook ❑ LinkedIn ❑ YouTube ❑ Instagram ❑ Google ❑ Bing ❑ Twitter ❑ SSMI Website ❑

Name (Doctor) _____

Name (Nutritionist) _____

Insurance company _____

Name (Therapist)_____

_____

Team / School Coach _____

Name (Trainer) _____

_____

Name (Friend) _____

Name (Other) _____

FINANCIAL AGREEMENT

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

Professional Fees:

PATIENT NAME:_____

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 the other professional service such as

1. Report writing
2. Telephone conversations with other professionals or family members
3. Preparation of records or treatment summaries
4. Legal proceedings, including preparation time and transportation
5. 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 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 hour notice** in advance to avoid a late cancellation or no show fee of $100.00 for Doctor visit and/or $150.00 for Testing - No Show.

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

_____

Patient or Parent/Guardian Name in Print

_____

Patient/Parent/Guardian Signature Date