ADVANCED ORTHOPEDICS

Advanced Sports & Orthopedics
Outpatient Imaging Services
3401 North Center Street Ste 100
Lehi, Utah 84043

PATIENT INFORMATION

Date _____ SS#: _____

Last Name_____ First Name _____ Middle Initial _____

Address _____

City _____State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Email Address _____

Sex: M F Birthdate_____ Employer_____

IN CASE OF EMERGENCY

Name _____ Relationship _____

Home Phone (____) _____ Cell Phone (____) _____

Referring Physician _____

Primary Insurance _____

Policy Holder _____ Holder's Birthdate _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Secondary Insurance _____

Policy Holder _____ Holder's Birthdate _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

RELEASE OF INFO

(PATIENTS OVER THE AGE OF 18)

In compliance with HIPAA regulations, we are not allowed to discuss medical information or release medical records to anyone without the patient's consent. If you wish to have any medical information released to anyone other than yourself (spouse, family member or friend), on the phone or in person, please complete the information below. You have the right to remove this authorization at any time.

I _____, date of birth _____, authorize representatives of Advanced Sports and Orthopedics to release medical information or records to:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient's Signature: _____ Date: _____

ADVANCED ORTHOPEDICS

NEW PATIENT VISIT

Injury/Complaint:_____ ☐Left ☐Right ☐Both

Date of Onset/Length of Injury:_____

How did you get injured: _____

Describe your current symptoms: _____

What have you done to treat this:_____

INJURY DETAILS

Average pain score: 0 1 2 3 4 5 6 7 8 9 10

Pain best described as: ☐Sharp ☐Ache ☐Throbbing ☐Dull

Previous Injury/Issues in the same area? ☐No ☐Yes _____

Any of the following? ☐Bruising ☐Swelling ☐Abrasions/Cuts of the skin ☐**NONE**

Are you experiencing? ☐Numbness ☐Tingling ☐Radiating pain ☐**NONE**

Are you experiencing? ☐Popping ☐Locking ☐Grinding ☐Clicking ☐**NONE**

REVIEW OF SYSTEMS

☐Chills
☐Chest Pain
☐Irregular Heartbeat
☐Nausea or Vomiting
☐Shortness of Breath
☐Easy Bruising
☐Heartburn
☐Muscle Pain
☐Joint Stiffness
☐Seizures
☐Fainting Spells
☐Anaphylaxis
☐Other _____
☐**NONE**

MEDICAL HISTORY

☐Alcoholism
☐Anemia
☐Anaphylaxis
☐Arrhythmia
☐Asthma
☐Bleeding Disorder
☐Cancer
☐Depression/Anxiety
☐Diabetes
☐Gout
☐Heart Disease
☐Kidney Disease
☐Liver Disease
☐Lung Disease
☐Serious Injuries
☐Stomach Ulcers
☐Stroke
☐Thyroid Disorder
☐Other _____
☐**NONE**

SOCIAL HISTORY

Tobacco Use: ☐Never ☐Current ☐Past

Alcohol Use: ☐Never ☐Current ☐Past

Street Drug Use: ☐Never ☐Current ☐Past

Occupation: _____

SURGICAL HISTORY

Year	Procedure	Side

☐**NONE**

MEDICATIONS

Current medications and dosages

_____

_____

_____

☐**NONE**

MEDICATION ALLERGIES

_____

☐**NONE**

FAMILY HISTORY

Arthritis	☐Mom	☐Dad	☐Sibling
Bleeding Disorder	☐Mom	☐Dad	☐Sibling
Diabetes	☐Mom	☐Dad	☐Sibling
Heart Troubles	☐Mom	☐Dad	☐Sibling
High Blood Pressure	☐Mom	☐Dad	☐Sibling
Kidney Problems	☐Mom	☐Dad	☐Sibling

☐**NONE**

PRMR Pt Ref SHS LPHS Ins AlpPed Staff AlpFM Sign MtnPt

Dry Cr GOOG LHS IMF PT: FP: Other:

ADVANCED
ORTHOPEDICS

Consent to Treatment and Conditions of Service: As either the Parent, or authorized agent or legal representative of the Patient, I consent and agree to the terms and conditions of this agreement. I make the following consents, understandings, and agreements on my own behalf.

Consent for Services: I hereby consent to health care services that include any treatments, examinations, medications, and diagnostic procedures provided by ADVANCED Sports and Orthopedics, its physicians, employees, and independent contractors for the benefit of the Patient for this visit and any subsequent visits. I accept that there is some uncertainty involved in the health care services for which this consent is given. No promises of any particular outcome or successful result have been made. I release ADVANCED, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of ADVANCED or its employees.

During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or (treatment) procedures may be necessary. These procedures may be preformed by physician(s), technician, athletic trainer, or other healthcare professionals. If I have any questions concerning these procedures, I will ask my physician to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

Release of information: ADVANCED is required by law to make and keep records of the Patient's medical treatment. Use of my Health Information, including my health history, medication, and prescription information, may be available electronically or physically from current or past healthcare providers. I authorize ADVANCED to release all necessary information to any insurance company, health plan or other entity, which may be responsible for paying for my care.

Financial Responsibility and Payment for Services: I promise to pay for the services and durable medical equipment rendered by ADVANCED to me or for my benefit and will pay any applicable co-payments, deductibles, co-insurance, and DME that are not covered by a third party. I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are rendered.

Returned Checks: A $25.00 returned check fee is applied to all returned checks. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Estimates: Pre-treatment estimates are not guaranteed by this office or your Insurance company.The nature of your service or procedure may change while in progress, which would result in a change in cost. Also, depending on your medical benefits, you may be responsible for paying a portion of the billed amount through deductibles, coinsurances, or copayments. Any remaining balance above the estimate is patient/guarantor responsibility.

Auto Insurance: In the event it is determined by Auto Insurance/Third Party Liability Insurance/Workers' Compensation that illness or injury is not the results of a compensated Auto/Third Party Liability/ Workers' Compensation case, patient/guarantor agrees to pay usual and customary fees for services rendered.

Initial

_____We reserve the right to charge a fee of no more than $100 per missed appointment which are not cancelled with a 24 hour advance notice. "No Show" fees will be billed to the Patient/Guarantor.

_____ Balances over 60 days will incur a one time 6% late fee until paid in full. Balances over 120 days will have the option of being sent to an outside collection agency and the account will accrue all associated cost of collection (including a collection fee no greater than 40%), all legal fees of collections, with or without suit, including attorney fees and court fees. Your account in collection will also incur 1.5% per month interest rate until paid in full. You will be notified that your outstanding balance is being considered for collection.

_____ I authorize ADVANCED to send text messages and leave voice mails at the phone number listed on my patient information form for appointment reminders and follow up phone calls.

_____ I authorize ADVANCED to send my statements via text and email to the phone number and email listed on my patient information form.

Patient or Authorized Representative Signature:_____Date: _____

By signing above, I acknowledge I have read the above consent.

Relationship to Patient:_____