



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Sports & Orthopaedic Specialists is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Sports & Orthopaedic Specialists."

"It is our policy to provide a substitute health care provider, authorized by Sports & Orthopaedic Specialists to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities

for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership

In the event that Sports & Orthopaedic Specialists is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Sports & Orthopaedic Specialists is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Sports & Orthopaedic Specialists amend your protected health information. Please be advised, however, that Sports & Orthopaedic Specialists is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Sports & Orthopaedic Specialists.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Sports & Orthopaedic Specialists reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Sports & Orthopaedic Specialists is required by law to comply with this Notice.

Sports & Orthopaedic Specialists is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Should you have questions about any part of this notice or if you want more information about your privacy rights, please contact our practice manager by calling this office at 480.222.5601.

Complaints

Complaints about your Privacy rights or how Sports & Orthopaedic Specialists has handled your health information should be directed to our practice manager, by calling this office at 480.222.5601. If the practice manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the way this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201



Referral Source: _____ Type: _____

Thank you Sent Completed by: _____ Verified by: _____

Patient Registration Form

MRNO: _____

PATIENT INFORMATION:

Name: _____ Social Security #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Birth date: ____/____/____ Age: _____

E-Mail Address: _____ (Please notify MA if you would like access to your CCD.)

Preferred Pharmacy Name: _____ Cross Streets/Phone Number of Pharmacy: _____

Circle: Male/Female – Single/Married Ethnicity: _____ Employer: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT):

Name: _____ Social Security #: _____ - _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Birth date: ____/____/____ Age: _____

PRIMARY CARE AND REFERRAL INFORMATION (Complete information will allow us to correspond with your referring/primary physician):

Primary Care Physician: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Who Sent You to our Office: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (If this is a workman's comp injury the carrier information must be provided as the primary insurance):

Worker's Comp Injury: YES NO Date of Injury: _____ Auto Accident: YES NO Date of Accident: _____

PRIMARY Insurance: _____

ID#: _____ Group #: _____

Insured Name: _____

Insured Employer: _____

Insured Birth date: _____ Male or Female

Relationship to Patient: _____

SECONDARY Insurance: _____

ID#: _____ Group #: _____

Insured Name: _____

Insured Employer: _____

Insured Birth date: _____ Male or Female

Relationship to Patient: _____

EMERGENCY CONTACT:

In case of emergency contact: _____ Phone #: (____) _____ - _____ Relationship: _____

SIGNATURE:

My signature below affirms the following:

1. I authorize payment directly to Sports & Orthopaedic Specialists for my surgical and/or medical benefits. I understand that I am financially responsible for any charges not covered by my insurance, such as the anesthesiologist, surgical assistant, brace, medications, durable medical equipment or hospital fees.
2. There is a \$25.00 fee for No-Show/No-Call to any scheduled appointment.
3. Surgical Cancellation Fee: I understand that any surgical procedure must be cancelled **NO LATER than 72 hours prior to the Date of Surgery or an administrative charge of \$250.00 will be assessed to my account.**
4. I have received a copy of Sports & Orthopaedic Specialists Notice of Privacy Practices. I understand a copy of these privacy practices is also available on our website at www.sosportsmed.com, or upon request at the front desk.
5. I authorize release of medical information to my referring provider, the emergency contact listed above, and the individual listed below:

Name: _____ Relationship: _____ Phone: (____) _____ - _____

Patient or Guarantor Signature: _____ (Relationship) _____ Date: _____



FINANCIAL POLICY

Thank you for choosing Sports & Orthopaedic Specialists as your orthopaedic specialist. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. ____ I understand that if I do not have my insurance card, referral, completed new patient paperwork, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. ____ I understand if my account is not paid in full within 90 days, a \$100 collection-processing fee will be added to the outstanding balance and will be turned over to a collection agency for further processing. No additional appointments will be made for delinquent accounts until they are brought current.
3. ____ I understand that a \$35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash). Should I have more than one check returned for NSF, I will no longer be able to make payment by check to Sports & Orthopaedic Specialists.
4. ____ I understand that if I am unable to make a scheduled appointment I need to contact Sports & Orthopaedic Specialists at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A \$25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.
5. ____ Sports & Orthopaedic Specialists will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. **It is my responsibility to provide my insurance company with requested information needed to process claims for services. It is also my responsibility to notify Sports & Orthopaedic Specialists if there is a change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**
6. ____ I understand that there is a \$25 fee associated with medical records requests and completion of forms by a physician. I understand that I am responsible for these fees.
7. ____ I understand that I am ultimately responsible for payment of all services rendered.
8. ____ **I have read and I understand the above Financial Policy and I agree to abide by its terms.**

Printed Name of Patient/Guarantor

Relationship

Signature of Patient/Guarantor

Date

For Office Use Only:

Entered by: _____ MRNO: _____ Date: _____

SPORTS & ORTHOPAEDIC SPECIALISTS
Craig H. Weinstein, MD, MPH, PC

Date	___/___/20___	By: _____
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NP ND NC FU PO

PATIENT INFORMATION					
Patient's last name:	First:	Middle:	Likes to be called:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Lives: (city/community): <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Retired <input type="checkbox"/> Household		Birthplace:		Marital status (circle one): Single / Mar / Div / Sep / Wid	
Name of school/employer:			Type of work:		

SPORTS	
Football Baseball Soccer Basketball Tennis Swimming Softball Golf Other: _____	None
<input type="checkbox"/> Professional <input type="checkbox"/> Minor /Semi-pro <input type="checkbox"/> Elite <input type="checkbox"/> Collegiate <input type="checkbox"/> High-school <input type="checkbox"/> Jr. organized <input type="checkbox"/> Competitive <input type="checkbox"/> Recreational	
Position:	Team/Club:

REASON FOR APPOINTMENT	
Side: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both	Area (circle): Shoulder / Elbow / Knee / Other (specify) _____
When did symptoms first start?	How?
Previous treatment (circle): Yes / No	If so, by who?
<input type="checkbox"/> PT/Therapy <input type="checkbox"/> Braces <input type="checkbox"/> Orthotics <input type="checkbox"/> Injections <input type="checkbox"/> Anti-inflammatory medications <input type="checkbox"/> Other medications <input type="checkbox"/> Surgery	
If you have had surgery, when (give date)? ___/___/___ Where? _____	
Surgery performed by (name of surgeon): _____	
What was done? _____	

INJURY/ACCIDENT				
Is this condition the result of?	<input type="checkbox"/> Yes <input type="checkbox"/> No Accident/Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No Workplace injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No MVA?	<input type="checkbox"/> Yes <input type="checkbox"/> No Other personal injury?
Have you contacted an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is so, who?			
Is any legal action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No				

REFERRAL					
Referred by: <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Family <input type="checkbox"/> Other Patient <input type="checkbox"/> Hospital employee <input type="checkbox"/> Doctor					
Name of PMD / Referring physician:					
Should information be sent to?	<input type="checkbox"/> Yes <input type="checkbox"/> No Primary care doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No Referring doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No Coach	<input type="checkbox"/> Yes <input type="checkbox"/> No Athletic trainer	<input type="checkbox"/> Yes <input type="checkbox"/> No Agent

Patient Medical History

Name:		MRNO:	
Date:		Referred By:	

CHIEF COMPLAINT	
Why are you here today?	
Which side is involved? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	Pain scale: (least) 1 2 3 4 5 6 7 8 9 10 (worst)
Describe your pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Ache <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing	
What makes it better?	
What makes it worse?	
Do your symptoms? <input type="checkbox"/> Interfere with normal activities <input type="checkbox"/> Interefere with sports <input type="checkbox"/> Interefere with work	
Are your symptoms present? <input type="checkbox"/> All the time <input type="checkbox"/> At night <input type="checkbox"/> At rest <input type="checkbox"/> With activity	
Do you experience any? <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Radiations <input type="checkbox"/> Stiffness	

MEDICATIONS			
Please bring all medications to your appointment			
	Medication	Dose/Frequency	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			
<input type="checkbox"/> Vitamins		<input type="checkbox"/> Glucosamine/chondroitin	<input type="checkbox"/> Other supplements <input type="checkbox"/> Baby / regular aspirin daily

ALLERGIES						
Are you allergic to any of the following?						<input type="checkbox"/> No Known Drug Allergies
(Check all that apply)	Itch	Rash	Muscle soreness	Stomach problems	Difficulty breathing	Other
<input type="checkbox"/> Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Keflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Steroid injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Shellfish	<input type="checkbox"/> Iodine	<input type="checkbox"/> Dye/contrast	<input type="checkbox"/> Eggs	<input type="checkbox"/> Tape/adhesive		
Other allergies:						
Serious side effects?						

OPTIONAL	In the event it would become necessary to provide a copy of your medical records to another health care provider, including your primary care physician, please sign below authorizing the release of your records for this purpose.
Signature:	Date:

Name:	MRNO:
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SURGERIES / HOSPITALIZATIONS

#	Type of Surgery	Year	Surgeon?	Where?
1.				
2.				
3.				
4.				
5.				

Have you ever had general anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had problems with anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SOCIAL HISTORY

Occupation:	Employed By:
Work Status:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Restricted
<input type="checkbox"/> Disabled <input type="checkbox"/> Retired	<input type="checkbox"/> Work At Home <input type="checkbox"/> Student
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Children:	<input type="checkbox"/> No <input type="checkbox"/> Yes How Many? Do you live alone? <input type="checkbox"/> No <input type="checkbox"/> Yes
Exercise?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never
What type of exercise?	
Are you on a special diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
History of substance abuse?	<input type="checkbox"/> No <input type="checkbox"/> Yes Describe:
Smoke currently?	<input type="checkbox"/> Never <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day for _____ years.
Quit smoking?	<input type="checkbox"/> This year <input type="checkbox"/> Last year <input type="checkbox"/> What year?
Previously smoked	Packs per day for _____ years.
Drink alcohol?	<input type="checkbox"/> Never <input type="checkbox"/> Daily <input type="checkbox"/> 1-2x per week <input type="checkbox"/> How much?

FAMILY HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M
				<input type="checkbox"/> F
Mother				<input type="checkbox"/> M
			<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F	
	<input type="checkbox"/> M		<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F	
	<input type="checkbox"/> M		<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F	
	<input type="checkbox"/> M		Grandmother	
	<input type="checkbox"/> F		<i>Maternal</i>	
	<input type="checkbox"/> M		Grandfather	
	<input type="checkbox"/> F		<i>Maternal</i>	
<input type="checkbox"/> M		Grandmother		
<input type="checkbox"/> F		<i>Paternal</i>		
<input type="checkbox"/> M		Grandfather		
<input type="checkbox"/> F		<i>Paternal</i>		

Are there any diseases that "run" in your family? (If so, please list)

Name: _____	MRNO: _____
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MEDICAL HISTORY / SYSTEMS REVIEW

General	Yes	No
Fever		
Sweats		
Weakness		
Fatigue		
Chills		
Unexplained weight loss / gain		

Hematologic	Yes	No
Easy bruising		
Anemia		
Blood clots		
Pulmonary embolus		
Hemophilia		
Transfusions		
Swollen glands		

Musculoskeletal	Yes	No
Rheumatoid arthritis		
Osteoarthritis		
Lupus / SLE		
Gout		
Fibromyalgia		
Trigger points		
PMR		
Polio		
Psoriasis		
Low back pain		

Cardiovascular	Yes	No
High blood pressure		
Coronary disease		
Heart attack / MI		
Chest pain		
Shortness of breath		
Heart murmur		
Swollen ankles		
Pacemaker		
Congenital defect		

Gastrointestinal	Yes	No
GERD / Reflux		
Hepatitis		
Irritable bowel		
Ulcer		
Diarrhea		
Constipation		
Jaundice		
Cirrhosis		
Liver failure		
Diverticulosis		
Gall bladder disease		

Renal / Kidney	Yes	No
Kidney stones		
Bladder infection		
Blood in urine		
Frequency		
Urgency		
Hesitancy		
Kidney failure		
Dialysis		

Respiratory	Yes	No
Asthma		
COPD / emphysema		
Bronchitis		
Shortness of breath		
Cough		
Tuberculosis / TB		

Neurologic	Yes	No
Stroke / CVA		
Seizure / epilepsy		
Headache / migraine		
Neuropathy		
Numbness / tingling		
Weakness		
Paralysis		
Dominant hand: _____ Right _____ Left		

Psychiatric	Yes	No
Depression		
Anxiety		
Bipolar		
Mood disorder		
Schizophrenia		
Drug abuse		
Alcohol abuse		

Endocrine	Yes	No
Diabetes		
Hyperthyroidism (High)		
Hypothyroidism (Low)		
High Cholesterol		

Ear, nose, throat, eyes	Yes	No
Wear glasses		
Cataracts		
Glaucoma		
Sinusitis		
Seasonal allergies / AR		
Blurred vision		
Nosebleeds		
Hearing loss		

Infection	Yes	No
HIV		
AIDS		
HTLV		
Hepatitis		
Osteomyelitis		

Broken Bones (Please List)

Please list any additional medical problems that you feel we should know about:

SPORTS & ORTHOPAEDIC SPECIALISTS

SPORTS & ORTHOPAEDIC SPECIALISTS OF ARIZONA, LLC

3487 S. Mercy Road • Gilbert, Arizona 85296

Tel 480-222-5601 • Fax 480-222-5607

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: Last First MI MRNO: _____
Patient's Date of Birth: _____ Social Security Number: _____
Phone # _____ Fax # _____ Email _____
Patient's address: _____
City: _____ State: _____ Zipcode: _____

**Please Check
Appropriate
Box**

- I hereby authorize **SOS** to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW
- I hereby authorize the PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to **SOS**

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE# _____ FAX# _____

- FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:
1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
 2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661)
 3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.)
 4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
 5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801)

I may revoke this authorization at any time providing I notify the above listed doctors in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. **I HEREBY RELEASE Sports & Orthopaedic Specialists, LLC FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM ANY ACT AUTHORIZED ABOVE. This release expires one year from date signed.**

Signature of Patient

Date Signed

Parent/Legally Authorized Representative

Relationship to Patient

Reason patient was unable to sign release: _____
PATIENTS 18 YEARS AND OLDER MUST SIGN OWN RELEASE