Parker Sports Medicine 7000 W. 9th Ave. • Amarillo, TX • 806-350-2663 • Fax 806-350-2664

Patient Information **Today's Date** _____

Last Name_____ First Name_____ MI_____ Male/Female _____

Date of Birth____/_____/_____Age_____ Home Phone _____Cell Phone/Carrier_____

Mailing/Physical Address_____ Apt #_____

City _____State _____Zip _____ Email Address _____

Social Security#_____-____-_____ Marital Status_____ Race/Ethnicity _____ Primary Language_____

Employer / School_____ Employer/ School City _____Employer/School phone #_____

IF MARRIED: Name of Spouse _____ Cell / Alternate Phone#_____

RESPONSIBLE PARTY INFORMATION NOTE: The Responsible Party is the person who obtains insurance coverage for themselves and/ or their dependents.

Full Name _____ Address _____Apt #_____

City _____State_____ Zip _____Phone#_____

DOB _____/_____/_____ SSN _____--_____--_____ Employer _____

Employer Address _____ Employer Phone #_____-_____

Parent/s or Guardian (if minor) _____

EMERGENCY CONTACT NAME (NOT IN SAME HOUSEHOLD) _____

Address _____City _____State _____Zip _____

Phone # _____ Relationship to Patient _____

Insurance Information (Complete All Insurance Information Thoroughly)

Primary Insurance: _____ Subscriber Name_____

Employer _____ Subscribers DOB _____/_____/_____ Relationship_____

Secondary Insurance: _____ Subscriber Name _____

Employer _____Subscribers DOB _____/_____/_____ Relationship _____

- ***I certify that the information provided is correct. I understand that the information provided will be used to manage my account and process insurance claims.***
- ***I understand that the insurance is filed as a courtesy to me and there may be a difference between my benefits and fees.***
- ***I assign payment of medical benefits to: James R. Parker, M.D. – Parker Sports Medicine and Orthopedics.***

Signature _____ ***Date*** _____***Relationship***_____

Patients Name: _____

PARKER SPORTS MEDICINE OFFICE POLICIES

Insurance

The patient is responsible for providing Parker Sports Medicine with the correct insurance information and obtaining any referrals required by the insurance company. Please bring photo identification and current insurance card to every visit.

The patient is responsible for responding to requests from the insurance company to provide any additional information they may require. If this information is not provided and they do not pay us because of the delay, the account will become due and payable in full at that time. Contrary to common understanding, all procedures (e.g., injections, aspirations, simple hardware removal) are considered surgical procedures by most insurance companies, so the fees for these services may apply to a separate surgical deductible, copayment, or coinsurance.

We accept most major insurance companies including, but not limited to, Medicare, BCBS, IMS, Aetna, United Health Care, Humana, City of Amarillo and Tricare. We accept most Medicare replacement plans. We do **not** accept Superior Chips/Medicaid and Amerigroup Medicaid. Please call the office or check your insurance website to see if we are in-network.

Payment

All copayments and deductibles are due at the time of the office visit. Any remaining balance after the insurance has paid is the patient's responsibility and is due upon receipt of the bill. If your account has a balance due, please plan to pay that balance before or at the time of any upcoming appointment. Patients without insurance coverage should be prepared to pay the visit balance on the date of the visit. We accept cash, checks, Visa, MasterCard, Discover, American Express, and CareCredit. Past due accounts are turned over to a collection agency.

Medical Records

Medical records can be obtained by the patient or sent to another office with completion of a written request. A fee may be charged for these records. Please allow 24 hours for all requests to be completed.

HIPAA

All medical records are protected as required by law. Copies of our privacy policy are available at our office.

Prescriptions

Please bring a list of all medications the patient is taking (including over-the-counter medicines) to each visit.

To request a prescription refill, please call our office with the patient's name, date of birth, preferred pharmacy, and name of the desired prescription. Some prescriptions may require an office visit to be refilled.

_____X Patients/Guardians Initials

Name _____ Date _____

What problem/s are you being seen for today? (Please indicate right, left, or both):

☐ Finger (R, L, B)	☐ Elbow (R,L, B)	☐ Toe (R, L, B)	☐ Knee (R, L, B)
☐ Hand (R, L, B)	☐ Upper Arm (R, L, B)	☐ Ankle (R, L, B)	☐ Thigh (R, L, B)
☐ Wrist (R, L, B)	☐ Shoulder (R, L, B)	☐ Foot (R, L, B)	☐ Hip (R, L, B)
☐ Forearm (R, L,B)	☐ Neck	☐ Lower Leg (R, L, B)	☐ Back

Date of Injury: _____ **Place of Injury** (ex. Home/Work/School) and **how it occurred**: _____

_____ Diagnostic Studies (Circle One): X-rays, MRI, CT , Other: _____

Location & Date: _____ Who referred you to us? _____ Is this a second opinion? Y or N

Hand Dominance: Right or Left Height: _____ Weight: _____ lbs

MEDICAL HISTORY QUESTIONNAIRE

Pharmacy: Name- _____ Location- _____

Medications: Please list all current (prescribed and over-the-counter) medications you are taking: If you have list, turn in when returning form. _____(med)- _____(doctor)

_____(med)- _____(doctor) _____(med)- _____(doctor)

_____(med)- _____(doctor) _____(med)- _____(doctor)

_____(med)- _____(doctor) _____(med)- _____(doctor)

Allergies: Are you allergic to any medication? ☐ No ☐ Yes

If yes, please list medication (type, date, and provider): _____;

_____;_____; _____

Operations: Have you ever had surgery? ☐ No ☐ Yes

If yes, please list operation (type, date, and provider): _____; _____;

_____; _____; _____;

Lifestyle:

Do you smoke? ☐ No ☐ Yes ☐ Former ☐ Smokeless

Cigarettes/cans per day?_____ How many years? _____ How long quit? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much daily? _____

History of drug abuse? ☐ No ☐ Yes

(Check all that apply and list physician treating you for each problem)

□ Hypertension -_____	□ Cancer (list type)- _____
□ High cholesterol- _____	□ Stroke (ischemic/hemorrhagic)- _____
□ Kidney Disease- _____	□ CAD: Coronary Artery Disease-_____
□ Stomach Ulcers- _____	□ PVD: Peripheral Vascular Disease-_____
□ GI Disease- _____	□ Heart Failure- _____
□ Diabetes- _____	□ History of blood Clots- _____
□ Asthma- _____	□ HIV/AIDS- _____
□ COPD- _____	□ MRSA- _____
□ Thyroid- _____	□ Gout- _____
□ Neurologic Disease- _____	□ Seizures- _____
□ Malignant Hyperthermia- _____	□ Other-_____

→

REVIEW OF SYSTEMS

(Please check all that you are currently experiencing)

EYES
- □ Eye disease
- □ Wear Glasses
- □ Blurred or double vision

EAR/NOSE/THROAT
- □ Hearing loss or ringing
- □ Chronic sinus problems
- □ Nose bleeds
- □ Sore throat
- □ Swollen glands in neck

CARDIOVASCULAR
- □ Heart trouble
- □ Chest pain/angina
- □ Palpitation
- □ Heart Murmur
- □ Hypertension

RESPIRATORY
- □ Chronic cough
- □ Shortness of breath
- □ Asthma
- □ Emphysema/COPD

GASTROINTESTINAL
- □ Loss of appetite
- □ Nausea/vomiting
- □ Frequent diarrhea
- □ Constipation
- □ Abdominal pain

MUSCULOSKELETAL
- □ Joint pain
- □ Joint stiffness or swelling
- □ Weakness of muscles
- □ Muscle pain/cramps

GENITOURINARY
- □ Frequent urination
- □ Burning/painful urination
- □ Blood in urine
- □ Hernia

INTEGUMENTARY
- □ Rash or itching
- □ Change in skin color
- □ Change in hair or nails

NEUROLOGICAL
- □ Frequent headaches
- □ Light headed/dizzy
- □ Numbness/tingling
- □ Seizures/tremors
- □ Paralysis

PSYCHIATRIC
- □ Memory loss/confusion
- □ Nervousness
- □ Depression
- □ Insomnia

FAMILY HISTORY: Please indicate if any member of your family (mother, father, sister, brother, uncle, aunt, etc.) have ever been treated for any of the following. If yes, please list the relatives relationship to you.

ILLNESS	RELATIONSHIP	ILLNESS	RELATIONSHIP
Stroke: (maternal/paternal)		Bleeding problems: (M/P)	
Hypertension: (maternal/paternal)		Anemia/Sickle Cell: (M/P)	
Heart problems: (maternal/paternal)		Diabetes: (M/P)	
High cholesterol: (maternal/paternal)		Rheumatoid/Arthritis: (M/P)	
Lung problems: (maternal/paternal)		Seizures: (M/P)	
Kidney disease: (maternal/paternal)		Drug abuse: (M/P)	
Cancer: (maternal/paternal)		HIV/AIDS: (M/P)	
Malignant hyperthermia: (maternal/paternal)		Other: (M/P)	

Patient/Parent Signature X _____ Date _____

PARKER
SPORTS MEDICINE & ORTHOPEDICS

Parker Sports Medicine and Orthopedics
7000 W. 9th Avenue
Amarillo, TX 79106
Phone: 806-350-2663 Fax: 806-350-2664

Authorization for the Disclosure of Health Information

Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Telephone Number: _____
Address: _____

I hereby authorize and request Parker Sports Medicine and Orthopedics to ☐ provide to or ☐ receive from:
Name/Facility: _____
Address: _____
Phone Number: _____ Fax Number: _____

This type and amount of information to be used or disclosed is as follows:
Specify date(s) of Encounter(s)/Hospitalization(s): _____

____Complete Medical Record ____History & Physical ____Operative Report
____Physician's Office Progress Notes ____Lab Reports ____Problem List
____X-Ray Reports ____X-Ray Films ____Discharge Summary
____Photographs, Videotapes, digital or other images ____Other_____

with regard to _____ medical/hospital records for the purpose of:
(Patient Name)

☐ Continuity of Care ☐ Billing and Payment of Bill ☐ Other (explain)_____

I understand that this authorization can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance upon this authorization. This authorization applies to the following: hospitals, medical providers, school officials, athletic trainers, coaches, and family members.

This authorization if for full disclosure of all health data which may include any information related to care for my impairment(s), information about how my impairment(s) affects my ability to complete tasks and activities of daily living, information about how my impairment(s) affect my ability to work; and/or related to drug, alcohol, mental health, psychiatric conditions, and/or sexually transmitted disease, Sickle Cell Anemia, including AIDS/HIV information (42 CFR part 2). Such records will be disclosed unless you specify information that you wish to be excluded.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 16-524. If I have questions about disclosure of my health information, I can contact Parker Sports Medicine and Orthopedics.

Facsimile transmission of this form will be deemed as having the same force and effect as an original. The risks associated with the use of facsimile transmission are understood.

This form☐ was read BY me ☐ was read TO me. I have been offered the opportunity to ask questions about this form, and I fully understand its contents and meaning. All blanks were filled in before the form was signed by me.

X_____ _____
Patient or Authorized Representative Signature Date
If signed by Legal Representative, Relationship to Patient: _____

_____ _____
Witness Signature Date

Patient Name: _____

Advanced Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

Your private insurance may not pay for the item(s) or service(s) that are described below. Your private insurance does not pay for all of your health care costs. Your private insurance only pays for covered items and services when your private insurance rules are met. The fact that your private insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **your private insurance probably will not pay for-**

Items or Services:
Parker Sports Medicine and Orthopedics

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, 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 if you don't understand why your private insurance probably won't pay.
- Ask us how much these items or services will cost you (Estimate Cost: $____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. SIGN AND DATE YOUR CHOICE.

☐ Option 1: Yes. I want to receive these items or services.
I understand that my private insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my private insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my private insurance is making its decision. If my private insurance does pay, you will refund to me any payments I made to you that are due to me. If my private insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally either out of pocket or through any other insurance that I have. I understand I can appeal my private insurance's decision.

☐ Option 2: No. I have decided not to receive these items or services.
I will not receive these items or services. I understand that you will not be able to submit a claim to my private insurance and that I will not be able to appeal your opinion that my private insurance won't pay.

_____ X _____

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

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to your private insurance, your health information on this form may be shared with your private insurance. Your health information which your private insurance sees will be kept confidential by your private insurance.

Parker Sports Medicine and Orthopedics

Acknowledgement of Receipt of Notice of Privacy Policy

I, _____, acknowledge that I have received a copy of the Parker Sports Medicine and Orthopedics Notice of Privacy Policy.

X_____ X_____

Patient Signature Date

_____ _____

Signature of Patient's legal representative (if applicable) Date

_____ _____

Print Name of Patient's legal representative (if applicable) Relationship to patient

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FOR OFFICE USE ONLY:

Parker Sports Medicine and Orthopedics has made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.

_____

_____

_____

Name of Office Representative: _____

Date placed in Patient's chart: _____