PARKER SPORTS MEDICINE | 7000 W. 9TH - AMARILLO, TX 79106-1709 | (806) 350-2663

PATIENT INFORMATION

Date: _____

Last Name: _____ **First Name**: _____ **Date of Birth**: _____

Mailing Address: _____ **City, State, Zip:** _____

Phone: _____ **Social Security #:** _____ **Sex:** ☐ M ☐ F **Age:** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race/Ethnicity: _____ **Primary Language**: _____ **Email**: _____

Spouse Full Name: _____ **Phone**: _____

EMPLOYMENT/SCHOOL INFORMATION

Employer/School: _____ **Occupation:** _____

Mailing Address: _____ **City, State, Zip:** _____

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Last Name: _____ **First Name:** _____ **Relationship:** _____

Mailing Address: _____ **City, State, Zip:** _____

Phone: _____ **Social Security #:** _____ **Email:** _____

INSURANCE INFORMATION (PLEASE PROVIDE COPY OF INSURANCE CARDS)

Primary Insurance Company: _____ **Employer:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship:** _____

Secondary Insurance Company: _____ **Employer:** _____

Subscriber Name: _____ **Date of Birth:** _____ **Relationship:** _____

EMERGENCY CONTACT (NOT LIVING WITH PATIENT)

Name: _____ **Phone:** _____ **Relationship to Patient:** _____

CONSENT TO TREATMENT FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

- I certify that the information provided is correct and will be used to manage my account and process insurance claims. I am responsible for notifying the provider for any changes in insurances.
- I understand that the insurance is filed as a courtesy to me and there may be differences between my benefits and fees.
- I assign payment of medial benefits to: James R Parker M.D, Parker Sports Medicine and Orthopedics.

I certify that I have read this form and understand its contents.

Patient/Legally Authorized Person: _____ **Date:** _____ **Relationship:** _____

PARKER

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REASON FOR VISIT

The reason for today's visit : _____

Select area(s) of current pain. Please indicate right, left, or both:

Finger	☐ R ☐ L	Hand	☐ R ☐ L	Shoulder	☐ R ☐ L	Neck	☐
Elbow	☐ R ☐ L	Arm	☐ R ☐ L	Foot	☐ R ☐ L	Leg	☐ R ☐ L
Toe	☐ R ☐ L	Ankle	☐ R ☐ L	Hip	☐ R ☐ L	Back/Spine	☐
Knee	☐ R ☐ L	Wrist	☐ R ☐ L				

Age: _____ **Height**: _____ **Weight**: _____ **Hand Dominance**: ☐ Right ☐ Left **In pain for how long?**: _____

Diagnostic Studies: ☐ X-rays ☐ MRI ☐ CT Other: _____ **IS this a second opinion?** ☐ Y ☐ N

Location of Injury: _____ **Date of Injury**: _____

Who requested that you visit this office?

☐ Doctor (Name) _____ ☐ Other _____ ☐ Self-Referral

Was pain onset... ☐ Sudden? ☐ Gradual? **Please explain**: _____

What is the nature of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

Frequency? ☐ Constant ☐ Intermittent | Pain Level 1-10: _____

Are there associated symptoms? ☐ Swelling ☐ Numbness ☐ Weakness ☐ Locking ☐ Grinding ☐ Popping ☐ Stiffness

Since problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged **Does your pain wake you from sleep?** ☐ Yes ☐ No

What makes your symptoms worse? ☐ Activity ☐ Exercise ☐ Work ☐ Other: _____

Which makes you feel better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other: _____

Have you had to modify your activities? ☐ Yes ☐ No **Are you still able to play sports/exercise?** ☐ Yes ☐ No

Does it affect your activities of daily life (grooming/cleaning house/yard work)? ☐ Yes ☐ No

Which treatments you have tried for today's problem? ☐ Steroid Injection ☐ HA (rooster-comb) injection ☐ Therapy/HEP

☐ Cane/Crutch ☐ Chiropractor ☐ Medicines ☐ Other: _____

Have you had prior problems with this SAME orthopedic condition in the past? ☐ Y ☐ N (explain below)

If yes, when? _____

What Diagnostic tests have you had for this problem and brought with you?

☐ X-rays ☐ Bone Scan ☐ Myelogram ☐ MRI ☐ EMG/NCS ☐ Ultrasound ☐ CT Scan ☐ Other _____

IS YOUR ILLNESS OR INJURY RELATED TO ANY OF THE FOLLOWING?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State): _____ Other: _____

If Employment related, has employer been notified? ☐ Yes ☐ No **Litigation pending?** ☐ Yes ☐ No

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MEDICATION HISTORY

Pharmacy Name: _____ **Location**: _____

Medications: Please list all current (prescribed and over-the-counter) medications you are taking.

Med, dosage:	Med, dosage:	Med, dosage:	Med, dosage:
Med, dosage:	Med, dosage:	Med, dosage:	Med, dosage:
Med, dosage:	Med, dosage:	Med, dosage:	Med, dosage:

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list & explain:

_____

Are you allergic to any metals? ☐ No ☐ Yes If yes, please list & explain: _____

Are you on blood thinners? ☐ No ☐ Yes **Reactions to anti-inflammatories?** _____

LIFESTYLE

Do you smoke? ☐ No ☐ Yes ☐ Former **Amount?** _____ **How long?** _____

Other Tobacco? ☐ Dip ☐ Chew ☐ Vape **Frequency**: _____ **How many years?** _____

Do you drink alcohol? ☐ No ☐ Yes ☐ Former If yes, how much daily/weekly? _____ ☐ History of Abuse

History of drug abuse? ☐ No ☐ Yes **Hormone Replacement/Birth control**: ☐ No ☐ Yes **COVID Vaccination**: ☐ No ☐ Yes

Are you currently? ☐ Working ☐ In School **Occupation**: _____

SURGICAL HISTORY

Please select ALL surgeries you've had.

Body Part, L/R	Procedure	Surgeon	Date	Complications

☐ Tonsils/Adenoids	☐ Tubal ligation/Vasectomy	☐ C-Section	☐ Bariatric: _____
☐ Appendectomy	☐ Pacemaker/Defibrillator	☐ Thyroidectomy	☐ Bowel/Colon
☐ Cholecystectomy	☐ Spinal Cord Stimulator	☐ Myringotomy Tubes	☐ Hemorrhoidectomy
☐ Hernia	☐ Cardiac Stents	☐ Mastectomy/Lumpectomy	☐ Spine surgery
☐ Hysterectomy	☐ CABG	☐ Prostatectomy	

☐ Other(s): _____

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
- ☐ 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 affected by/taking medications for.

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

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

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

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

CHRONIC
- ☐ AIDS/HIV
- ☐ Bleeding Problems
- ☐ Stroke
- ☐ Arthritis
- ☐ Neuropathy
- ☐ Kidney Problems
- ☐ Pneumonia
- ☐ Gout

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

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

- ☐ MIgraines
- ☐ Hepatitis A, B, C
- ☐ Polio
- ☐ Heart Problems
- ☐ Thyroid
- ☐ Diabetes
- ☐ Blood Clots (DVT, PE)
- ☐ Epilepsy
- ☐ Psychiatric Disorders

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

PSYCHIATRIC
- ☐ Memory loss/confusion
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

- ☐ Anemia
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Stomach Problems
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Muscle Diseases
- ☐ Cancer (Type):

What physicians do you see regularly? Choose any applicable and provide physician name.

☐ PCP: _____ ☐ Cardiologist: _____ ☐ Rheumatologist: _____

☐ Endocrinologist: _____ ☐ Oncologist: _____ ☐ Pain Management _____

☐ Pulmonologist: _____ ☐ Other: _____

Have you ever had a reaction to anesthesia? ☐ No ☐ Yes Explain: _____

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	_____	☐ Lung problems	_____
☐ Bleeding problems	_____	☐ Seizures	_____
☐ Hypertension	_____	☐ Kidney disease	_____
☐ Anemia/Sickle Cell	_____	☐ Drug abuse	_____
☐ Heart problems	_____	☐ Cancer	_____
☐ Diabetes	_____	☐ HIV/AIDS	_____
☐ High cholesterol	_____	☐ Malignant hyperthermia	_____
☐ Rheumatoid/Arthritis	_____	☐ Other	_____

Patient/Parent Signature: _____ Date: _____

PARKER SPORTS MEDICINE OFFICE POLICIES

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following office policies. We are dedicated to providing the best possible care and service to you and regard you complete understanding of your financial responsibilities as an essential element of your care and treatment.

_____ (Initial)

FINANCIAL POLICY

Full payment is due at the time of service. For your convenience we accept Cash, Check, VISA, MasterCard, and Discover. If your account has a balance due, payment will be expected prior to your next appointment, unless prior arrangements have been made.

The patient is responsible for providing Parker Sports Medicine (PSM) with the correct insurance information and obtaining any referrals required by your insurance company for specialty care. All insurance companies are different, and sometimes have different tier levels of your benefits. We do the best we can to get accurate information and collect based on our fullest understanding of those benefits. Any balance left by the health plan is your responsibility and is due upon receipt of a statement from our office.

Additionally, 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 If provided, and they do not pay us because of the delay, then the full charges incurred will be turned over to the patient's responsibility, and payment is due immediately upon receiving a statement from our office.

In certain circumstances, payment plans are available if a patient is unable to pay the amount due in full. It is required to put a credit/debit card on file for automatic payments each month. If no card is available, it is the responsibility of the patient to ensure payment is made at least once monthly. Any amount due for services after the payment plan is initiated will be due at the time of service. If two (2) payments decline or are failed to be paid without communication to our billing office, the account will be turned over to the collection agency representing this medical practice.

- Any refund requested that was originally processed by a credit card will incur a 5% convenience fee.
- A $35 fee may be charged to you if reasonable notice of cancellation is not received within 24 hours of your appointment.

NON-INSURED PATIENTS

We do offer a time-of-service discount to non-insured patients. If you are unable to pay the discounted pricing at the time of service, the discount is forfeited, and payment must be made prior to your next appointment for our full fee. Our staff is more than happy to answer any financial questions you have prior to your appointment.

_____ (Initial)

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 five (5) business days to complete your request, but please be advised, by law, we have fifteen (15) days to respond to requests.

_____ (Initial)

PRESCIPTIONS

Please bring a list of all medications the patient is taking to each visit. To request a refill, please call our office to discuss eligibility of refill. Some prescriptions may require an office visit prior to fulfilling the request. By signing, you agree to have read and understand the office policies stated above.

_____ (Initial)

Patient/Guardian Signature: _____ Date: _____

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ADVANCED BENEFICIARY NOTICE (ABN)

Patient Name: _____ MRN: _____

NOTE: A decision must be made on this form before services will be rendered.

Your private insurance may or may not pay for the item(s) or service(s) that your physician is recommending today. Your private insurance only pays for covered items by their rule set, but that does not necessarily mean you shouldn't receive them. The purpose of this form is to help you make an informed choice about whether you want to receive these items or services provided by Parker Sports Medicine (PSM). 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 in case you have to pay for them yourself or through other insurance prior to seeing your doctor.

PLEASE CHOOSE ONE OPTION:

☐ OPTION 1: YES. I want to receive these items or services today and any future care recommended by my provider and bill to my private insurance regardless if they promise to pay or not. I understand that you will submit these claims to my private insurance and promise to do the best of your ability to get them to pay. If my insurance denies payment or asks for their payment back at any time for any reason, then I understand that I am fully responsible for the bill as I am choosing to receive these services. I understand that I can appeal my insurance's decision, but payment will be expected immediately, and I can ask for a refund* of my monies once insurance pays.

☐ OPTION 2: YES. I want to receive services today, but I choose to not use my private health insurance, or do not have any health insurance coverage to use.

☐ OPTION 3: NO. I have decided not to receive these items or services. I understand that you will not be able to provide service or submit a claim to my insurance company on my behalf today or until I revoke this decision in writing.

I, (print name) _____, agree to the following payment arrangements and understand that I can book surgery as soon as I have met the above requirements.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

I, (print name) _____, acknowledge that I have received a copy of the Parker Sports Medicine Notice of Privacy Policy, which describes how my health information is used and shared. I understand that this facility has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer of this facility. Upon signing, I understand that Parker Sports Medicine may discuss my Protected Health Information (PHI) and any account balance/ issues with the following people:

1. Name: _____ Relation to Patient: _____

2. Name: _____ Relation to Patient: _____

3. Name: _____ Relation to Patient: _____

Patient Signature: _____ Date: _____

Signature of Patient's Legal Representative (if applicable) _____ Date: _____

Printed Name of Patient's Legal Representative: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

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

Reasons why written acknowledgement was not obtained:

_____

_____

_____

Name of Office Representative: _____

Date Placed in Patient's Chart: _____

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AUTHORIZATION FOR THE DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____

I hereby authorize and request Parker Sports Medicine and Orthopedics to ☐ **provide to** or ☐ r**eceive from**:

Name/Facility: _____ **Address**: _____

Phone Number: _____ **Fax Number**: _____

This type and amount of information to be used or disclosed is as follows.

☐ Complete Medical Record	☐ Physician's Office Progress	☐ Problem List	☐ Discharge Summary
☐ History & Physical	☐ Notes	☐ X-Ray Reports	☐ Photographs, Videotapes
☐ Operative Report	☐ Lab Reports	☐ X-Ray Films	☐ Digital or other images

☐ Other _____

with regard to (patient) _____ 's medical/hospital records for the purpose of:

☐ 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 impairments) affects my ability to complete tasks and activities of daily living, information about how my impairments) affect my ability to work; and/or related to drug, to 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 understan‹ 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 or ☐ 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.

Patient or Authorized Representative Signature: _____ Date: _____

If signed by Legal Representative, Relationship to Patient: _____

Witness Signature: _____ Date: _____