SPARKS
ORTHOPEDICS & SPORTS MEDICINE

Patient Information:

Patient Name:_____Date of Birth:_____/_____/_____

Responsible Party (if minor)_____

Street Address: _____

City_____State_____ Zip_____

Sex: M or F Age_____ Marital Status (circle one) **Married Single Divorced Widowed**

Social Security Number _____/____/_____ Spouse Social Security Number _____/_____/_____

Patient Employer:_____

Business Address:_____

Occupation:_____ Business Phone ( ) -

Spouse Name:_____ Birth Date _____

Spouse Business Name & Address:_____

Spouse Occupation:_____ Business Phone ( ) -

In Case of Emergency, who should be notified?_____ Phone ( ) -

How did you learn of our practice?_____

Email address:_____

Date of Visit: (Today's Date)_____/_____/_____ Date of Injury (If Applicable):_____/_____/_____

Reason for Visit:_____

Primary Care Physician: _____ Referring Provider: _____

Height:_____ft____in Weight:_____lbs. Circle one: Right Handed Left Handed

Preferred Language:_____ Race:_____
Ethnicity:_____

Please initial_____

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Pharmacy Name:_____Pharmacy Number: (_____)_____-_____

Who is responsible for the account?_____

Relationship to the patient?_____

Do you have medical insurance (circle one)? Yes or No Insurance company_____

Name of Primary Insurer_____ Date of Birth_____Relationship_____

Social Security Number _____/____/_____ Contract#_____ Group#_____

Name of secondary insurer_____Contract#_____Group#_____

Prescription History Consent:

I give consent to have Sparks Orthopedics obtain my prescription from external sources:

Signature:_____**Date**:_____/_____/_____

_____

Financial & Privacy Policy

Thank You for Choosing Sparks Orthopedics, LLC., (Sparks) as your Healthcare Provider. The Following guidelines have been established to help you understand our expectations for our services.

Assignment of Benefits & Release (by signing this you state that)

I hereby assign and authorize payment directly to Sparks Orthopedics, LLC. all benefits payable under the terms of any insurance policy if insurance is filed by this office. I realize the insurance benefits may not pay the entire bill and agree to pay the difference or the entire bill if necessary. I authorize the release of any medical and medication information necessary to process my insurance claims or to continue my medical care.

Signature:_____Date:_____/____/_____

Payment in Full

You are responsible for your co-pay, any unmet deductibles, and “co-insurance” that your insurance plan considers your responsibility at the time of your visit. We gladly accept cash, checks, and most credit cards.

Insurance Claims

As a courtesy to our patients, we will file your primary and secondary insurance claims. In order for us to provide this service, we need to copy your most current insurance card and a picture ID. Any payment from your insurance company will come to Sparks for our services when we file for you. Please remember that insurance

Please initial_____

coverage is a contract between the patient and the insurance company, therefore any co-payments or deductibles are due at the time of your appointment. You will be responsible for any non-covered services. If your insurance payment is not received within 60(sixty) days, the balance will automatically be assigned to you for payment and will be due immediately.

This applies to Blue Cross plans only

According to Article 4 (IV) of the PMD agreement, each patient must sign notification of responsibility for payment of medical services in writing for services not covered under the PMD benefit agreement plan.

Article 10 (X) states that the patient will be responsible for any and all rendered professional services not covered by Blue Cross & Blue Shield of Alabama.

EXAMPLE: Services for experimental or investigative treatment, cosmetic surgery, pre-existing conditions, and routine check-ups.

The patient is responsible for all charges not covered by his/her insurance plan.

Usual & Customary Reimbursement

Our charges (fees) have been set to accurately reflect the complexity of care rendered and the skill and expertise required for your care. We assure you that our fees reflect what is usual and customary. If your insurance company's fee schedule falls below the level of charge, you will be responsible for payment in full (unless we have a written contract with your insurance company).

Self-Pay

You are required to pay in full when services are rendered if you have no insurance. Any payment arrangements must be made prior to seeing the physician.

Collection Policy

If your account becomes delinquent, and sent to an outside agency or attorney for collection you will be responsible for all costs, including agency fees, attorney fees, court costs, and any other related expenses. Your account will be changed to a "cash only" status and prepayment prior to service will be required.

You agree and waive all rights to claim personal property exempt under the laws of the state of Alabama.

Missed Appointments

Missing multiple scheduled appointments will result in dismissal from the practice.

HIPAA

I acknowledge that I have been offered and received a copy of the HIPAA policy.

Please initial_____

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Financial Hardship Policy

Please ask to speak to the billing department to discuss payment plans and options if you have a financial hardship. Please be prepared to present proof of the hardship including previous year's tax statements, outstanding debt, proof of income or proof of no income, and other documents as needed. Failure to establish a written payment policy with Sparks can result in your account being sent to an outside collection agency. This can result in additional legal fees and charges. **Sparks Orthopedics reports to credit agencies**.

Medicare Patients [This is for Medicare Patients Only]

We are participating physicians with Medicare. This means that you will be responsible for 20% of the approved Medicare fee, the yearly deductible and full payment of non-covered services. As a courtesy to our patients, CUA will file any secondary claims.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the providers at Sparks Orthopedics, LLC. for any services furnished to me by that provider. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:_____ Date:_____/_____/_____

By signing this, you acknowledge and agree to the financial terms and conditions of Sparks Orthopedics, LLC. You also acknowledge you have access and understand your rights under HIPAA Law

Signature_____ Date:_____/_____/_____

If you have any questions regarding Sparks' financial & HIPAA policy, we will be most happy to answer them for you.

Please initial_____

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Privacy Acknowledgement:

I acknowledge that I have received a Privacy Practices Notice from Sparks Orthopedics and Sports Medicine, LLC. Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment, and health care operations as discussed in the Notice of Privacy Practices.

I give permission for my personal information to be released to the following people:

		Medical	Financial
1.	Name _____ Relationship_____	◯	◯
2.	Name _____ Relationship_____	◯	◯
3.	Name _____ Relationship_____	◯	◯

Signature:_____ **Date**_____/_____/_____

Electronic Communications Consent: (Text, Email, etc.)

DO NOT USE ELECTRONIC COMMUNICATIONS TO SEND OR REQUEST SENSITIVE INFORMATION. DO NOT USE ELECTRONIC COMMUNICATIONS TO SEND INFORMATION THAT IS EMERGENT. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use electronic communications provided by your employer, then your employer may view that information. Sparks Orthopedics, LLC. cannot and does not guaranty the privacy or security of any messages being sent over the internet. There is a potential it can be read by others. If this is a concern to you then do not communicate using electronic communications. This document along with the Notice of Privacy Practices constitutes a privacy notice for electronic communication use.

I have been informed and understand the risks and procedures using electronic communications. I agree to the terms listed on this form and hereby voluntarily consent, request, and authorize the use of electronic communications as one form of communication with my physician, their associates, and other healthcare providers. (You may request a copy of this form to keep with your records)

Signature:_____**Date**:_____/_____/_____

Please initial_____

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Past Medical History (please check all that apply):

- ◯ Anemia, Chronic
- ◯ Anxiety
- ◯ Asthma
- ◯ Irregular Heartbeat
- ◯ Bipolar Disorder
- ◯ Breast Cancer
- ◯ Hyperlipidemia
- ◯ Ischemic Heart Disease
- ◯ Chronic Pain
- ◯ Colon Cancer
- ◯ COPD
- ◯ Coronary Artery Disease
- ◯ Deep Vein Thrombosis
- ◯ Depression
- ◯ Diabetes, Insulin Dependent
- ◯ Diabetes, NON Insulin
- ◯ End State Renal Disease
- ◯ GERD
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ High Cholesterol
- ◯ Hyperparathyroidism
- ◯ Hypertension
- ◯ Hyperthyroidism
- ◯ Hypothyroidism
- ◯ Leukemia
- ◯ Lung Cancer
- ◯ Lymphoma
- ◯ Multiple Myeloma
- ◯ Obesity, Morbid
- ◯ Obesity
- ◯ PBPH
- ◯ Prostate Cancer
- ◯ Pulmonary Embolism
- ◯ Radiation Therapy
- ◯ Fibromyalgia
- ◯ Rheumatoid Arthritis
- ◯ Sleep Apnea
- ◯ Seizures
- ◯ Stroke
- ◯ **None**
- ◯ Other

Past Surgical History (please check all that apply):

- ◯ Appendix (Appendectomy)
- ◯ Breast: Mastectomy
  - ◯ Right ◯ Left ◯ Both
- ◯ Breast Lumpectomy
  - ◯ Right ◯ Left ◯ Both
- ◯ Colectomy
- ◯ Colon Cancer Resection
- ◯ Colectomy: Diverticulitis
- ◯ Colectomy: IBD
- ◯ Colon Colostomy
- ◯ Gall Bladder Removal
- ◯ Heart: Biological Valve Replacement
- ◯ Heart: Coronary Artery Bypass Surgery
- ◯ Heart Transplant
- ◯ Heart: Mechanical Valve Replacement
- ◯ Heart: PTCA
- ◯ Kidney Stone Removal
- ◯ Kidney Transplant
- ◯ Liver: Hepatectomy
- ◯ Liver: Liver Transplant
- ◯ Liver: Shunt
- ◯ Ovaries Removed: Ovarian Cancer
- ◯ Ovaries Removed: Ovarian Cancer
- ◯ Ovaries: Tubal Ligation
- ◯ Pancreas: Pancreatectomy
- ◯ Prostate Removed: Prostate Cancer
- ◯ Prostate Removed (TURP)
- ◯ Rectum: APR
- ◯ Rectum: Low Anterior Resection
- ◯ Skin: Basil Cell Carcinoma
- ◯ Skin: Melanoma
- ◯ Skin: Skin Biopsy
- ◯ Skin: Squamous Cell Carcinoma
- ◯ Hysterectomy: Caesarean
- ◯ Hysterectomy: Caesarean
- ◯ Hysterectomy: Uterine Cancer
- ◯ Hysterectomy: Cervical Cancer
- ◯ **None**

Other:_____

Please initial_____

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Past Orthopedic History (please check all that apply)

- ◯ Ankle Fracture
- ◯ Ankylosing Spondylitis
- ◯ Bursitis
- ◯ DISH
- ◯ Epidural Injections, Spine
- ◯ Fracture
- ◯ Gout
- ◯ Hip Fracture
- ◯ HNP, Cervical
- ◯ HNP, Lumbar
- ◯ Metastatic Bone Disease
- ◯ Osteoarthritis
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Primary Bone Sarcoma
- ◯ Psoriatic Arthritis
- ◯ Rheumatoid Arthritis
- ◯ Ricketts
- ◯ RSD
- ◯ Sciatica
- ◯ Scoliosis
- ◯ Spine Fracture
- ◯ Soft Tissue Sarcoma
- ◯ Spinal Stenosis, Cervical
- ◯ Spinal Stenosis, Lumbar
- ◯ Vertebral Body Compression Fracture
- ◯ Vitamin D Deficiency
- ◯ Wrist Fracture
- ◯ None
- ◯ Other_____

Past Orthopedic Surgery (please check all that apply)

- ◯ Achilles Tendon Repair (○ Right ○ Left or ○ Both)
- ◯ ACL Reconstruction (○ Right ○ Left or ○ Both)
- ◯ Ankle Fracture ORIF (○ Right ○ Left or ○ Both)
- ◯ Bunion Correction (○ Right ○ Left or ○ Both)
- ◯ Carpel Tunnel Decompression (○ Right ○ Left or ○ Both)
- ◯ Cervical Spine Surgery: ACDF
- ◯ Cervical Spine Surgery: Disc Replacement
- ◯ Distal Radius ORIF (○ Right ○ Left or ○ Both)
- ◯ Ganglion Cyst Excision
- ◯ Intermedullary Nailing Femur (○ Right ○ Left or ○ Both)
- ◯ Intermedullary Nailing Tibia (○ Right ○ Left or ○ Both)
- ◯ Joint Replacement: Hip (○ Right ○ Left or ○ Both)
- ◯ Joint Replacement: Knee (○ Right ○ Left or ○ Both)
- ◯ Joint Replacement Shoulder (○ Right ○ Left or ○ Both)
- ◯ Knee Arthroscopy (○ Right ○ Left or ○ Both)
- ◯ Kyphoplasty/Vertebroplasty
- ◯ Lumbar Fusion
- ◯ Lumbar Laminectomy
- ◯ Lumber Spine surgery: Decompression
- ◯ Lumbar Spine Surgery: Decompression & Fusion
- ◯ Lumbar Spine Surgery: Disc Replacement
- ◯ Meniscus Repair (○ Right ○ Left or ○ Both)
- ◯ Reverse Total Shoulder Replacement (○ Right ○ Left or ○ Both)
- ◯ Revision of Total Knee Arthroplasty (○ Right ○ Left or ○ Both)
- ◯ Revision of Total Shoulder Arthroplasty (○ Right ○ Left or ○ Both)
- ◯ Rotator Cuff Repair (○ Right ○ Left or ○ Both)
- ◯ Shoulder Arthroscopy (○ Right ○ Left or ○ Both)
- ◯ Trigger Finger Release

  Location:_____

- ◯ Other_____

Please initial_____

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Medications (please list all current medications or check option that applies):

◯ I brought a copy of my medication list (please provide the list to the front receptionist)

◯ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check which option which applies):

◯ I brought a copy of my allergy list (please provide the list to the front receptionist)

◯ No known Allergies

Allergy Type	Please describe allergic reaction and severity of symptoms

Please initial_____

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Family History (please inform us of your family member's medical history by marking the appropriate box)

	Mother	Father	Sister	Brother	Daughter	Son	Other
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
Other_____							

◯ No Family History (checking here indicates no past family medical history)

Social History (please check all that apply):

Cigarette Smoking

◯ Never smoked

◯ Quit: former smoker

◯ Smokes less than daily

◯ Smokes daily

_____# Packs per day

Alcohol Use

◯ Do not drink alcohol

◯ Less than 1 drink per day

◯ 1-2 drinks per day

◯ 3 or more drinks per day

Exercise Frequency

◯ Several times per day

◯ Once a day

◯ Few times per week

◯ Few times per month

◯ Never

◯ Other_____

Do you have a living will? Yes / No

Have you recently had a flu vaccination? Yes / No

Have you had a pneumonia vaccination? Yes / No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

Yes Name_____ Phone Number_____

No

Which statement best reflects your wishes on advanced care recommendations?

a) Do not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
b) Do nor resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
c) Full cardiopulmonary resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Please initial_____

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Check Here if you have any of these Symptoms

	YES	NO		YES	NO
Joint Pains			Heartburn		
Joint Swelling			Nausea/Vomiting		
Joint Stiffness			Constipation		
Unsteady Gait			Diarrhea		
Numbness			Bloody/ tarry stools		
Tingling			Frequent urination		
Dizziness			Difficult/ painful urination		
Headaches			Incontinence		
Fatigue			Blood in urine		
Unexpected Weight Loss			Shortness of breath		
Fever			Wheezing		
Chills			Cough		
Weight gain			Anxiety/ Depression		
Poor healing wounds			Hallucinations		
Scarring/Keloids					
Easy Bleeding			**ALERT**		
Easy Bruising				YES	NO
Allergic reaction to food			Pacemaker		
Allergic reaction to environment			Blood thinners		
Chest pain			Defibrillator		
Palpitations			Pregnant		
Heart murmur			Planning a Pregnancy		
Excessive thirst or urination			RSD		
Heat/ Cold intolerance			Allergy to shellfish/ iodine		
Nose bleeds			Allergy to Latex		
Ringing in ears			Allergy to adhesive		
Hoarseness			Under pain management		
Corrective lenses			HIV Positive		
Blurred vision			Hepatitis position (A,B, or C)		

Please initial_____