SPORTS & ORTHOPAEDIC SPECIALISTS

REGISTRATION FORM

MRNO: _____ Thank you Sent

Referral Source: _____ Referral Type: _____

Entered By: _____ Verified By: _____

Patient's Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth : _____ Age: _____ Gender: ☐ Female ☐ Male

Address: _____ Cell Phone: _____Other: _____

City:_____ State: _____ Zip: _____ Email: _____

Social Security Number: _____ Preferred confidential contact: Phone Cell Email

Marital Status: ☐ S ☐ M ☐ D ☐ W Preferred language: _____ Race: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to answer Were you injured at work? ☐ Yes ☐ No

Employer: _____ Employer Phone Number: _____

Employer Address: _____ Patient's Occupation: _____

City, State, Zip: _____

Pharmacy name: _____ Phone number: _____ Cross Streets:_____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Phone: _____

Relationship to Patient: _____

Primary Care Physician: _____ Who sent you to our office: _____

If person responsible for payment is different from patient, then complete the following section.

Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Home Phone:_____ Cell Phone: _____

Primary Insurance:

Insurance name: _____

Policy ID# / Claim #: _____

Group/Account #: _____

Policy Holder Name: _____

DOB: _____

SS#: _____

Relationship to patient: _____

Secondary Insurance:

Insurance name: _____

Policy ID#: _____

Group / Account #: _____

Policy Holder Name: _____

DOB: _____

SS#: _____

Relationship to patient: _____

My signature below affirms the following:

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. I agree that all information provided is true and correct. I understand that should I fail to provide Sports & Orthopaedic Specialists with accurate and up to date insurance information, I am fully financially responsible for all incurred charges.

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

SPORTS & ORTHOPAEDIC SPECIALISTS

Policies and Procedures Agreement

FOR OFFICE USE ONLY:

MRNO: _____

Verified By: _____

Initials: _____

Patient Information: Patient/Guarantor demographic information must be reviewed at each appointment to ensure we have the most current information; this includes providing us with the most current insurance card. We cannot be held responsible if we are unable to reach you for any reason due to incorrect contact/demographic information. 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.

Initials: _____

Payment of Services: Payment for services received at Sports & Orthopaedic Specialists is the sole responsibility of the patient/guarantor. By signing this form you accept full financial responsibility for services rendered.
Insured Patients: It is your responsibility to know your insurance benefits, terms, and exclusions. **Your insurance company will NOT notify our office of changes/termination of your policy.** For this reason it is your responsibility to notify our office of changes to your insurance policy/plan. We are not responsible for the denial of insurance claims due to incorrect or outdated insurance information; you will be billed and held financially responsible for the balance should this occur. Charges not covered by your insurance company such as anesthesiologist, surgical assistant, brace, medications, durable medical equipment and/or hospital fees, etc., are the financial responsibility of the patient/guarantor.

Initials: _____

Co-Pays: If your insurance company requires you to pay a co-pay to our office, we are in turn required to collect that co-pay at the time of service. If you are unable to pay your co-pay at the time you check-in for your appointment, the billing department will go over alternate payment options with you.

Initials: _____

Other Fees: I understand that there is a $25 fee associated with medical records requests and completion of forms by a physician. If I request my X-Rays be placed on a disc there is a $15 fee. If I request a "peer to peer" physician review for insurance purposes there is a $50 fee. I understand that I am responsible for these fees.

Initials: _____

Financial Disclosure: Your physician may have a financial interest in certain services or products used in your care. Examples include but are not limited to ambulatory surgical facilities, imaging, and certain pharmaceutical products.

Initials: _____

Medication Agreement: Narcotics and/or controlled substances are only prescribed by our providers if a surgery is performed. Once a provider at SOS has given a prescription for such substances, SOS will be in control of all drugs associated with pain management and you cannot obtain such substances from any other health care provider or pharmacy unless approved through an SOS provider.

Initials: _____

Consent to Treat a Minor: All minor patients must be accompanied by their legal parent/guardian for their first (New Patient) appointment at Sports & Orthopaedic Specialists. For any visit after the initial intake appointment, the parent or legal guardian can designate another adult to bring the minor in for medical care. Should it be necessary to send your minor child with a relative, friend, sibling, etc., we need you to complete the "Consent to Treat a Minor" form included in this packet for future reference.

Initials: _____

Release of Medical Information: Release of Medical Records to my emergency contact and/or my referring provider is authorized and acknowledged by my initials and signature of this form.

Initials: _____

Notice of Privacy Practices: There is a copy of Sports & Orthopaedic Specialists Notice of Privacy Practices available at the front desk (check-in), and on our website at www.sossportsmed.com. The form can be emailed, faxed or mailed to you at your request. By signing and initialing this form, you acknowledge that you have access to and have read and agreed to the Notice of Privacy Practices.

By signing this form I agree that I have read, acknowledge, understand and agree to the items listed above:

_____ _____

Patient/Guarantor Signature Date

_____ _____

Printed Name of Patient/Guarantor 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.

1. _____ 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 $50 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

2. _____ A $350 surgery booking fee is required prior to scheduling your surgery. The details will be explained to you on the day of your surgery consult.

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. _____ 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.**

5. _____ I understand that as the insured member, I am responsible for knowledge and understanding of my plan's benefit requirements. Many carriers require referrals for certain services therefore; I am responsible for verifying a referral is on file for my visit.

6. _____ 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.

7. _____ I understand that I am ultimately responsible for payment of all services rendered.

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: _____

Revised 1/6/17 BK

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: _____ _____ _____ RNO:_____
Last First MI

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