

Dear Patient,

It is important that you follow the guidelines listed below in order to help ensure you are seen in a timely manner and that correct data regarding your visit is obtained. (Please initial where indicated.)

- _____ The first 30 to 45 minutes of your appointment will be spent with check-in, insurance, paperwork and x-ray and you should allow at minimum, 2 hour for your visit.
- _____ It is **mandatory** that you bring all insurance cards, forms, drivers' license, policy numbers, and referral letters with you at the time of your appointment so that the proper billing and insurance approval may be accomplished
- _____ **If you cannot make your appointment, we respectfully ask that that you notify our office forty-eight (48) hours in advance. If you are late for your appointment, please call ahead and notify our office, you may need to reschedule for a different date and time. We appreciate your cooperation.**
- _____ Current/Prior relative imaging (Xray, MRI, CT **ON CD ONLY**) should be brought the day of your appointment to determine if additional imaging is required.
- You may be asked to change into a gown and/or shorts for your exam. For your comfort, you may choose instead to follow these recommendations (be mindful that there could be instances when you will be asked to wear a gown/shorts) :
 - **Knee exams:** Wear loose fitting non-denim pants/shorts (no snaps, buttons, zippers, or plastic)
 - **Hip exams:** Wear non-denim shorts, sweatpants, athletic pants, or pull on type pants (no snaps, buttons, zippers, plastic or metal grommets, embroidery or screen printing)
 - **Back exams:** Wear non-denim pants & a sports bra (no snaps, buttons, zippers, plastic or metal grommets, screen printing or embroidery).
 - **Shoulder exams:** Wear a sports bra (no snaps, buttons, or underwire)
 - **Hospital Campus/Office policy:** No Weapons allowed beyond your vehicle.

So that our sign in area doesn't become congested, anyone accompanying you is free to be seated while you check in. We appreciate the opportunity to provide you with orthopedic care. Should you have any additional questions, do not hesitate to call our office at 205-939-3699.

COVER PAGE

My appointment is with Dr. _____ on (date) _____ at (time) _____

OR

I submitted an online request for an appointment with Dr. _____

Signature: _____ Date: _____

Pre-registration allow us to validate your demographic and insurance more quickly during your visit. This saves you time in the waiting room and helps us move your appointment along more quickly!

On the day that you arrive, we will simply ask you for your insurance card(s) and driver license. Please use this cover page and FAX your paperwork to 205-314-2559 at least 2 days prior to your appointment. If at all possible please also scan a legible copy of your insurance card(s) and driver license along with your registration forms (please no photo's) and email it to: registration@andrewscenters.com.

If it's less than 24 hours before your appointment: To prevent any delay before your visit, please bring your registration paperwork with you instead of emailing or faxing it; our office needs 24 hours to process registrations that are faxed/emailed.

“Andrews Sports Medicine and Orthopaedic Center complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex”.

Name: _____
Date of Birth _____
Date: _____



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NAME: _____
LAST FIRST M.I. NAME TO BE CALLED

SEX: _____ DATE OF BIRTH: _____ SS# _____

ADDRESS: _____
STREET NUMBER & NAME OR P.O.BOX CITY STATE ZIP

PRIMARY PHONE _____ ALTERNATE PHONE _____ WORK PHONE _____

PATIENT EMPLOYER: _____ EMAIL: _____

EMERGENCY CONTACT: _____ CONTACT # _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED LIFE PARTNER
NAME & RELATION OF PERSON OUTSIDE IMMEDIATE HOME

NAME OF SPOUSE: _____ SPOUSE EMPLOYER: _____

CURRENT SCHOOL: _____ SPORT/OCCUPATION: _____ POSITION: _____

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO DECLINE TO ANSWER

RACE: (MARK ONE OR MORE) AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN AMERICAN
 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE DECLINE TO ANSWER

PREFERRED LANGUAGE: _____

BODY PART: _____ LEFT RIGHT

DATE INJURY/ACCIDENT OCCURRED: MONTH DAY YEAR

HOW DID INJURY/ACCIDENT OCCUR: _____

PRIMARY INS CO: _____ SECONDARY INS CO: _____

POLICY HOLDERS NAME: _____ POLICY HOLDERS NAME: _____

RELATIONSHIP TO PT: _____ RELATIONSHIP TO PT: _____

DATE OF BIRTH: _____ SS# _____ DATE OF BIRTH: _____ SS# _____

CONTRACT#: _____ GROUP#: _____ CONTRACT#: _____ GROUP#: _____

POLICY HOLDER'S EMPLOYER: _____ POLICY HOLDER'S EMPLOYER: _____

EFFECTIVE DATE: _____

IS THIS A WORKMAN COMPENSATION CASE? YES NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

DATE INJURY/ACCIDENT OCCURRED: MONTH DAY YEAR

WHERE INJURY/ACCIDENT OCCURRED: CITY: _____ STATE: _____

EMPLOYER: _____ WORK COMP CARRIER: _____

ADDRESS: _____
STREET NUMBER & NAME OR P.O.BOX CITY STATE ZIP

IF 19 YEARS OLD OR YOUNGER PLEASE COMPLETE THE FOLLOWING INFORMATION:

MOTHER'S NAME: _____ ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

FATHER'S NAME: _____ ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

Name: _____
 Date of Birth _____
 Date: _____



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Pharmacy: _____ Phone: _____ Location: _____
 Primary Care Physician _____ Phone: _____

CURRENT MEDICATIONS:

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING ASPIRIN & SUPPLEMENTS

MEDICATIONS	DOSAGE	FREQUENCY
1		
2		
3		

MEDICATIONS	DOSAGE	FREQUENCY
4		
5		
6		

DRUG ALLERGIES: YES NO

LATEX ALLERGY: YES NO

ARE YOU CURRENTLY UNDER PAIN MANAGEMENT? NO YES DOCTOR _____

IF YES, PLEASE LIST ALL DRUG ALLERGIES

PREVIOUS HOSPITALIZATIONS/SURGICAL PROCEDURES:

PLEASE PROVIDE DATES

TYPE OF SURGERY	YEAR
1	
2	

TYPE OF SURGERY	YEAR

FAMILY MEDICAL HISTORY:	Father	Mother	Sibling	Children
Arthritis				
Osteoporosis				
Diabetes				

	Father	Mother	Sibling	Children
High Blood Pressure				
High Cholesterol:				
Other:				

SOCIAL HISTORY:

CHECK APPROPRIATE BOXES & FILL IN BLANKS

MARRIED SINGLE DIVORCED WIDOWED OTHER
 ALCOHOL: NONE OCCASSIONAL DAILY HEAVY
 TOBACCO: Never Former Current every day Current some day _____ Packs per day Date Started _____
 OCCUPATION: _____ Hand Dominance: Right Left
 HEIGHT: _____ WEIGHT: _____ B/P(IF KNOWN): _____ / _____

REVIEW OF SYSTEMS/GENERAL HISTORY:

PLEASE CIRCLE YES OR NO

GENERAL	YES	NO	GASTROINTESTINAL	YES	NO	RESPIRATORY	YES	NO
WEIGHT CHANGE			DIFFICULTY SWALLOWING			COUGH/SPUTUM		
FEVER OR CHILLS			JAUNDICE			TUBERCULOSIS		
NIGHT SWEATS			HEPATITIS			SHORTNESS OF BREATH		
BLEEDING			REFLUX			ASTHMA		
LUMPS OR MASSES			ULCER			EMPHYSEMA		
DIZZINESS OR FAINTING			<u>CARDIOVASCULAR</u>			COPD		
CANCER type: _____			CHEST PAIN			SLEEP APNEA		
<u>EAR-EYE-NOSE-THROAT</u>			HEART DISEASE			<u>GENITOURINARY</u>		
VISUAL CHANGE			HIGH BLOOD PRESSURE			URINARY INFECTIONS		
HEARING CHANGE			ATRIAL FIBRILLATION			INCONTINENCE		
RINGING IN EARS			DEFBRILLATOR			URINARY FREQUENCY		
BLEEDING GUMS			PACEMAKER			VENERAL DISEASE		
<u>MUSCULOSKELETAL</u>			STENTS			MENOPAUSE		
JOINT PAIN			HEART FAILURE			KIDNEY DISEASE		
JOINT SWELLING			MITRAL VALVE PROLAPSE			DIALYSIS		
BACKACHE			BLOOD CLOTS			<u>PSYCHOLOGICAL</u>		
RHEUMATOID ARTRITIS			<u>NEUROLOGICAL</u>			DEPRESSION		
<u>ENDOCRINE</u>			SEIZURES			BIPOLAR		
DIABETES TYPE 1			NUMBNESS			ADD/ADHD		
DIABETES TYPE 2			WEAKNESS			OTHER		
THYROID PROBLEM			<u>SKIN</u>			OTHER		
UNLISTED _____			ITCHING OR RASH			AIDS/HIV		
			LATEX ALLERGY			MRSA		

WILL YOU ACCEPT A BLOOD TRANSFUSION IF NECESSARY ? YES NO

Have you ever had complications with anesthesia ? YES NO

Do you have a personal or family history of malignant hyperthermia ? YES NO

PHYSICIAN REVIEW	
SIGNATURE	DATE

PATIENT SIGNATURE (if over 14 years old) _____ DATE _____

Name: _____

Date of Birth _____

Date: _____



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Sports Medicine & Orthopaedic Center

805 St. Vincent's Drive • Suite 100 • Birmingham, Alabama 35205

Authorization for Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Andrews Sports Medicine and Orthopaedic Center. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Andrews Sports Medicine and Orthopaedic Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information and has refused to retain a copy.

Release of Information: Andrews Sports Medicine and Orthopaedic Center is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopaedic technicians and/or coaches. I agree that Andrews Sports Medicine and Orthopaedic Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I also authorize Andrews Sports Medicine and Orthopaedic Center to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Andrews Sports Medicine and Orthopaedic Center for application on the patient's bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services such as, **DURABLE MEDICAL SUPPLIES, SYNVISIC, SUPARTZ, SYNVISIC ONE**, and any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialist and by physicians for whom Andrews Sports Medicine and Orthopaedic Center is authorized to bill. I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33% collection fee, attorney fees, and/or court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. All delinquent balances shall bear interest at the legal rate. Complete payment policies can be found at AndrewsSportsMedicine.com

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits. either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Miscellaneous Provisions: I consent to receive calls and/or text messages regarding my healthcare information and other healthcare-related services at the phone number(s) given. I understand I may be charged for calls to my wireless phone by my wireless carrier, and that calls may be generated by a I automated dialing system. I further understand that I may revoke this consent at any time by notifying my healthcare provider in writing. I understand that under no circumstances will Andrews Sports Medicine and Orthopaedic Center be liable for property of patients.

Surgical Consent: I understand that my surgery may overlap with another procedure my doctor is scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery, but may not be present for my entire surgery. The physician may supervise a surgical team which could include another attending surgeon, a surgery fellow, surgery resident or a physician's assistant. Qualified members of this team may perform parts of the surgery. I understand that my surgeon or another credentialed surgeon will be immediately available should the need arise during my surgery. Upon scheduling a surgery, I will be given an opportunity to ask any questions or voice concerns about this or my procedure.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

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UNDERSIGNED (Patient's Signature if over 14 years of age)

Signature - Parent / Responsible party

RELATIONSHIP TO UNDERSIGNED

MONTH DAY YEAR TIME
A.M.
P.M.

WITNESS - NEED ONLY IF SIGNATURES ARE MADE BY MARK (X)
Ver. 3/2017

DATE AND TIME OF SIGNING

Name: _____

Date of Birth: _____

Date: _____



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Sports Medicine & Orthopaedic Center

Medical Information Release Form (HIPAA Release Form)

If over age 14, you must choose one of the following options:

- Information is not to be released to anyone without further authorization.
- I authorize the release of my medical information by Andrews Sports Medicine and Orthopaedic Center ("Andrews") including diagnoses, records, test results, exams, and reports to the individuals listed below.
- I authorize the release of my billing/financial information by Andrews to the individuals listed below.
- I authorize the release of both my complete medical and billing/financial information by Andrews to the individuals listed below.

Information to be released is for the following date(s) of services and/or types of services: _____

(Examples of individuals listed below may include non-treating physicians, trainers, coaches, parents, guardians, spouses, or any other individuals authorized to receive the patient's information.)

Name: _____ Relationship to patient: _____

Method of Release: Fax: _____ Phone: _____ Pick-up: _____
 Mail: _____

Name: _____ Relationship to patient: _____

Method of Release: Fax: _____ Phone: _____ Pick-up: _____
 Mail: _____

Name: _____ Relationship to patient: _____

Method of Release: Fax: _____ Phone: _____ Pick-up: _____
 Mail: _____

- **Description of information to be disclosed and purpose:** I authorize the practice to disclose the patient's protected health information specified above to the individual(s) designated above at my request. I understand that this will result in the disclosure of the patient's confidential information.
- **Expirations or termination of authorization:** Unless terminated by the patient, the patient's personal representative or another individual(s) legally authorized to do so by court order or law, this authorization will remain in effect for one (1) year.
- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager, but such revocation will not have any effect on disclosures made prior to receipt of the revocation. Revocation can be done in-person or by mailing a request to: ATTN: Privacy Officer: Andrews Sports Medicine, 805 St. Vincent's Drive, Suite 100, Birmingham, Alabama 35205
- **Redisclosure:** I understand that the information to be released may be subject to redisclosure by the recipient and no longer protected by federal or state laws.
- **Voluntary Authorization:** I understand that this authorization is voluntary. I may refuse to sign this authorization and the patient's treatment and/or payment obligations will not be affected unless (1) the treatment is related to research and the disclosure is related to such research; (2) the treatment is solely for the purpose of creating health information for disclosure to a third-party.
- **Remuneration:** I understand that Andrews will not receive financial or in-kind compensation or remuneration in exchange for the disclosure of the patient's health information unless an applicable legal exception exists.
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I consent to receive calls, and/or text messages regarding my healthcare information and other healthcare-related services at the phone number(s) given. I understand I may be charged for calls to my wireless phone by my wireless carrier, and that calls may be generated by a I automated dialing system. I further understand that I may revoke this consent at any time by notifying my healthcare provider in writing.

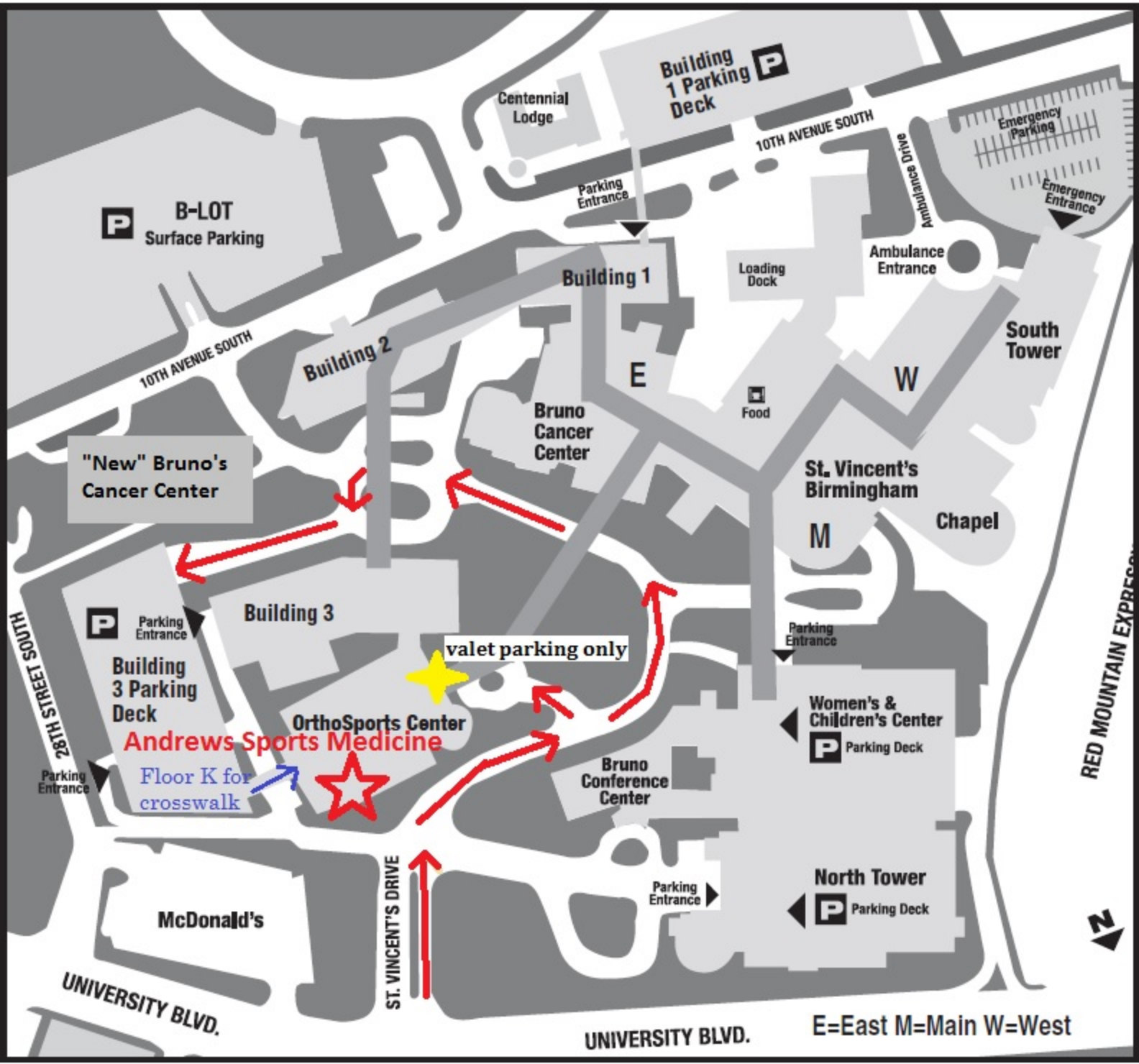
The best time to reach me is (*day*) _____ between (*time*) _____

Signature of Patient: _____ Date: ____ / ____ / ____

(If over 14 years of age)

Signature of Patient's Personal Representative: _____ Date: ____ / ____ / ____

(If applicable)



P B-LOT Surface Parking

Building 1 Parking Deck **P**

Emergency Parking
Emergency Entrance

10TH AVENUE SOUTH

10TH AVENUE SOUTH

Ambulance Drive
Ambulance Entrance

Building 2

Building 1

Loading Dock

Ambulance Entrance

South Tower

"New" Bruno's Cancer Center

Bruno Cancer Center

Food

St. Vincent's Birmingham

Chapel

M

P Parking Entrance

Building 3

valet parking only

Parking Entrance

28TH STREET SOUTH

Building 3 Parking Deck

OrthoSports Center

Andrews Sports Medicine

Floor K for crosswalk

Bruno Conference Center

Women's & Children's Center
P Parking Deck

Parking Entrance

McDonald's

ST. VINCENT'S DRIVE

Parking Entrance

North Tower
P Parking Deck

RED MOUNTAIN EXPRESSWAY

UNIVERSITY BLVD.

UNIVERSITY BLVD.

E=East M=Main W=West

