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 resehedule 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.

<u>If it's less than 24 hours before your appointment:</u> 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: ____________________

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: __________ (NAME & RELATION OF PERSON OUTSIDE IMMEDIATE HOME) CONTACT # __________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LIFE PARTNER

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 __________

____________________ ____________________

Ver. 3/2017 DATE FC6

Name: ____________________
Date of Birth ____________
Date: ________________

ANDREWS
Sports Medicine & Orthopaedic Center

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 IF YES, PLEASE LIST ALL DRUG ALLERGIES
ARE YOU CURRENTLY UNDER PAIN MANAGEMENT? ☐ NO ☐ YES DOCTOR ____________________

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		
WEIGHT CHANGE	YES	NO
FEVER OR CHILLS	YES	NO
NIGHT SWEATS	YES	NO
BLEEDING	YES	NO
LUMPS OR MASSES	YES	NO
DIZZINESS OR FAINTING	YES	NO
CANCER type: ________	YES	NO
EAR-EYE-NOSE-THROAT		
VISUAL CHANGE	YES	NO
HEARING CHANGE	YES	NO
RINGING IN EARS	YES	NO
BLEEDING GUMS	YES	NO
MUSCULOSKELETAL		
JOINT PAIN	YES	NO
JOINT SWELLING	YES	NO
BACKACHE	YES	NO
RHEUMATOID ARTRITIS	YES	NO
ENDOCRINE		
DIABETES TYPE 1	YES	NO
DIABETES TYPE 2	YES	NO
THYROID PROBLEM	YES	NO
UNLISTED ____________		

GASTROINTESTINAL		
DIFFICULTY SWALLOWING	YES	NO
JAUNDICE	YES	NO
HEPATITIS	YES	NO
REFLUX	YES	NO
ULCER	YES	NO
CARDIOVASCULAR		
CHEST PAIN	YES	NO
HEART DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO
ATRIAL FIBRILLATION	YES	NO
DEFBRILLATOR	YES	NO
PACEMAKER	YES	NO
STENTS	YES	NO
HEART FAILURE	YES	NO
MITRAL VALVE PROLAPSE	YES	NO
BLOOD CLOTS	YES	NO
NEUROLOGICAL		
SEIZURES	YES	NO
NUMBNESS	YES	NO
WEAKNESS	YES	NO
SKIN	YES	NO
ITCHING OR RASH	YES	NO
LATEX ALLERGY	YES	NO

RESPIRATORY		
COUGH/SPUTUM	YES	NO
TUBERCULOSIS	YES	NO
SHORTNESS OF BREATH	YES	NO
ASTHMA	YES	NO
EMPHYSEMA	YES	NO
COPD	YES	NO
SLEEP APNEA	YES	NO
GENITOURINARY		
URINARY INFECTIONS	YES	NO
INCONTINENCE	YES	NO
URINARY FREQUENCY	YES	NO
VENERAL DISEASE	YES	NO
MENOPAUSE	YES	NO
KIDNEY DISEASE	YES	NO
DIALYSIS	YES	NO
PSYCHOLOGICAL	YES	NO
DEPRESSION	YES	NO
BIPOLAR	YES	NO
ADD/ADHD	YES	NO
OTHER	YES	NO
OTHER		
AIDS/HIV	YES	NO
MRSA	YES	NO

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: ____________

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, SYNVISC, SUPARTZ, SYNVISC 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 3arty
	RELATIONSHIP TO UNDERSIGNED
WITNESS - NEED ONLY IF SIGNATURES ARE MADE BY MARK (X)	MONTH | DAY | YEAR | TIME A.M. P.M. — DATE AND TIME OF SIGNING

Ver. 3/2017

FC3

Name: ______________________________

Date of Birth: ________________

Date: ____________________

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)

Building 1 Parking Deck

Centennial Lodge

10TH AVENUE SOUTH

Emergency Parking

Emergency Entrance

Ambulance Drive

B-LOT Surface Parking

Parking Entrance

Building 1

Loading Dock

Ambulance Entrance

South Tower

Building 2

E

W

Food

Bruno Cancer Center

"New" Bruno's Cancer Center

St. Vincent's Birmingham

Chapel

M

Building 3

Parking Entrance

valet parking only

Parking Entrance

Building 3 Parking Deck

OrthoSports Center

Andrews Sports Medicine

Floor K for crosswalk

Parking Entrance

28TH STREET SOUTH

Women's & Children's Center

Parking Deck

Bruno Conference Center

RED MOUNTAIN EXPRESSWAY

Parking Entrance

North Tower

Parking Deck

McDonald's

ST. VINCENT'S DRIVE

UNIVERSITY BLVD.

UNIVERSITY BLVD.

E=East M=Main W=West