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: _____
Chart: _____
Date: _____

Andrews Sports Medicine

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 _____ ☐ Home ☐ Work ☐ Cell
ALTERNATE PHONE _____ ☐ Home ☐ Work ☐ Cell
WORK PHONE _____ ☐ Home ☐ Work ☐ Cell

PATIENT EMPLOYER: _____ EMAIL: _____

EMERGENCY CONTACT: _____ CONTACT # _____
NAME & RELATION OF PERSON OUTSIDE IMMEDIATE HOME

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: _____ **Language**

BODY PART: _____ LEFT ☐ RIGHT ☐

DATE INJURY/ACCIDENT OCCURRED: MONTH _____ DAY _____ YEAR _____

HOW DID INJURY/ACCIDENT OCCUR: _____

PRIMARY INS CO: _____
POLICY HOLDERS NAME: _____
RELATIONSHIP TO PT: _____
DATE OF BIRTH: _____ SS# _____
CONTRACT#: _____ GROUP#: _____
POLICY HOLDER'S EMPLOYER: _____

SECONDARY INS CO: _____
POLICY HOLDERS NAME: _____
RELATIONSHIP TO PT: _____
DATE OF BIRTH: _____ SS# _____
CONTRACT#: _____ GROUP#: _____
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 _____

_____ _____
DATE

Andrews Sports Medicine Medical History

Patient Name: _____ Chart: _____
Primary Phone: _____ Date: _____
Pharmacy _____ Phone: _____ Zip _____ Location: _____
Primary Care M.D. _____ Phone: _____ Fax: _____
Cardiologist _____ Phone: _____ Fax: _____

MEDICAL HISTORY (*check all that apply*) ☐ **I HAVE NO KNOWN MEDICAL PROBLEMS**

☐ Heart Disease	☐ Seizures	☐ MRSA	☐ Diabetes; Type ___	☐ Kidney Disease
☐ Atrial Fibrillation	☐ COPD/Emphysema	☐ Cancer	☐ Thyroid Disorder	☐ Liver Disease
☐ High Blood Pressure	☐ Asthma	☐ Ulcer	☐ Rheumatoid Arthritis	☐ Hepatitis;Type___
☐ Prior Blood Clot	☐ Sleep Apnea	☐ Reflux	☐ Fibromyalgia	☐ HIV/AIDS
☐ Stroke/TIA	☐ Tuberculosis	☐ Menopause	☐ Gout/Pseudogout	☐ Depression/Anxiety

☐ Other: _____

CURRENT MEDICATIONS: (*please list **ALL** current medications along with **dose & frequency**. Include aspirin & supplements)*

			Select if using: ☐ Pain Medication
			☐ Blood thinner ☐ Chemotherapy
			☐ Birth Control ☐ Chronic Steroids

Currently under Pain Management? ☐ No ☐ Yes Doctor _____ Condition _____

ALLERGIES: ☐ None ☐ Latex ☐ Eggs/Chicken ☐ Nickel ☐ Penicillin
☐ Medications (describe reaction) _____

PRIOR SURGERY *(include ALL)* ☐ Pacemaker ☐ Defibrillator ☐ Cardiac Stent(s)

Will you accept blood transfusion if necessary? ☐ Yes ☐ No **Any prior complications with anesthesia?** ☐ Yes ☐ No
Do you have a personal or family history of Malignant Hyperthermia? ☐ Yes ☐ No

FAMILY HISTORY:	Parent	Sibling
Arthritis		
Diabetes		
Heart Disease		
Clotting Disorder		
Osteoporosis		
Unknown Family History		

SOCIAL HISTORY (*check appropriate box and fill in blanks)*

Marital Staus	**Alcohol**	**Tobacco**	**Drug Use**
☐ Single	☐ None	☐ Never ☐ Smokeless	☐ Never ☐ Prior
☐ Married	☐ Rarely	☐ Former; Stopped _____	☐ Current IV Use
☐ Divorced	☐ Weekly	☐ Current	☐ Other
☐ Widowed	☐ Daily	# packs per day _____	**Hand Dominance**
☐ Other	# drinks____	# years smoked _____	☐ Right ☐ Left

Occupation/School/Sports/Hobbies: _____

REVIEW OF SYSTEMS (*please circle yes or no)*

HEIGHT: _____ **WEIGHT:** _____

General		**Cardiovascular**		**Gastrointestinal**		**Skin**	
Weight Gain/Loss	Yes/No	Chest Pain	Yes/No	Nausea/Vomiting	Yes/No	Rash/Itching	Yes/No
Fever/Chills	Yes/No	Palpitations	Yes/No	Diarrhea	Yes/No	**Neurological**	
Night Sweats	Yes/No	Heart Murmur	Yes/No	**Endocrine**		Numbness	Yes/No
Fatigue	Yes/No	**Respiratory**		Increased Thirst	Yes/No	Weakness	Yes/No
Dizziness	Yes/No	Cough/Sputum	Yes/No	Excessive Hunger	Yes/No	Tremor/Shaking	Yes/No
Ear-Eyes-Nose-Throat		Difficulty Breathing	Yes/No	**Genitourinary**		**Psychological**	
Vision Change	Yes/No	**Musculoskeletal**		Urinary Infections	Yes/No	Depression	Yes/No
Ringing in Ears	Yes/No	Joint Pain	Yes/No	Incontinence	Yes/No	Panic attacks	Yes/No
Nose Bleeds	Yes/No	Backache	Yes/No	Dialysis	Yes/No	Mood Swings	Yes/No
Hard to Swallow	Yes/No	Muscle Pain	Yes/No				

Patient Signature *(if over 14 y/o)* **Date**

Provider Signature (reviewed) **Date**

Name: _____

Date of Birth: _____

Date: _____

Andrews Sports Medicine

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 www.andrewscenters.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.

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.

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.

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.

"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".

Patient's Signature _____ Date: _____

if over 14 years of age

Parent / Responsible party _____ Date: _____

Please Print

Parent / Responsible party _____ _____

Signature ***RELATIONSHIP***

Name: _____
Chart: _____
Date: _____

Andrews Sports Medicine

Medical Information Release Form (HIPAA Release Form)

If age 14 or over, 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: _____

_____

Patient Portal Release: Choose One

☐ Access to my patient portal is not to be released to anyone without further authorization.

☐ I authorize the people listed below to full access to my Patient Portal which contains my Andrews medical information, billing/financial information, and the ability to securely communicate with Andrews on my behalf.

---

*(Examples of individuals listed below may include non-treating physician, spouses, trainers, coaches, if 14 or older **PARENTS**, **GUARDIANS**, 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 disclousre 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.

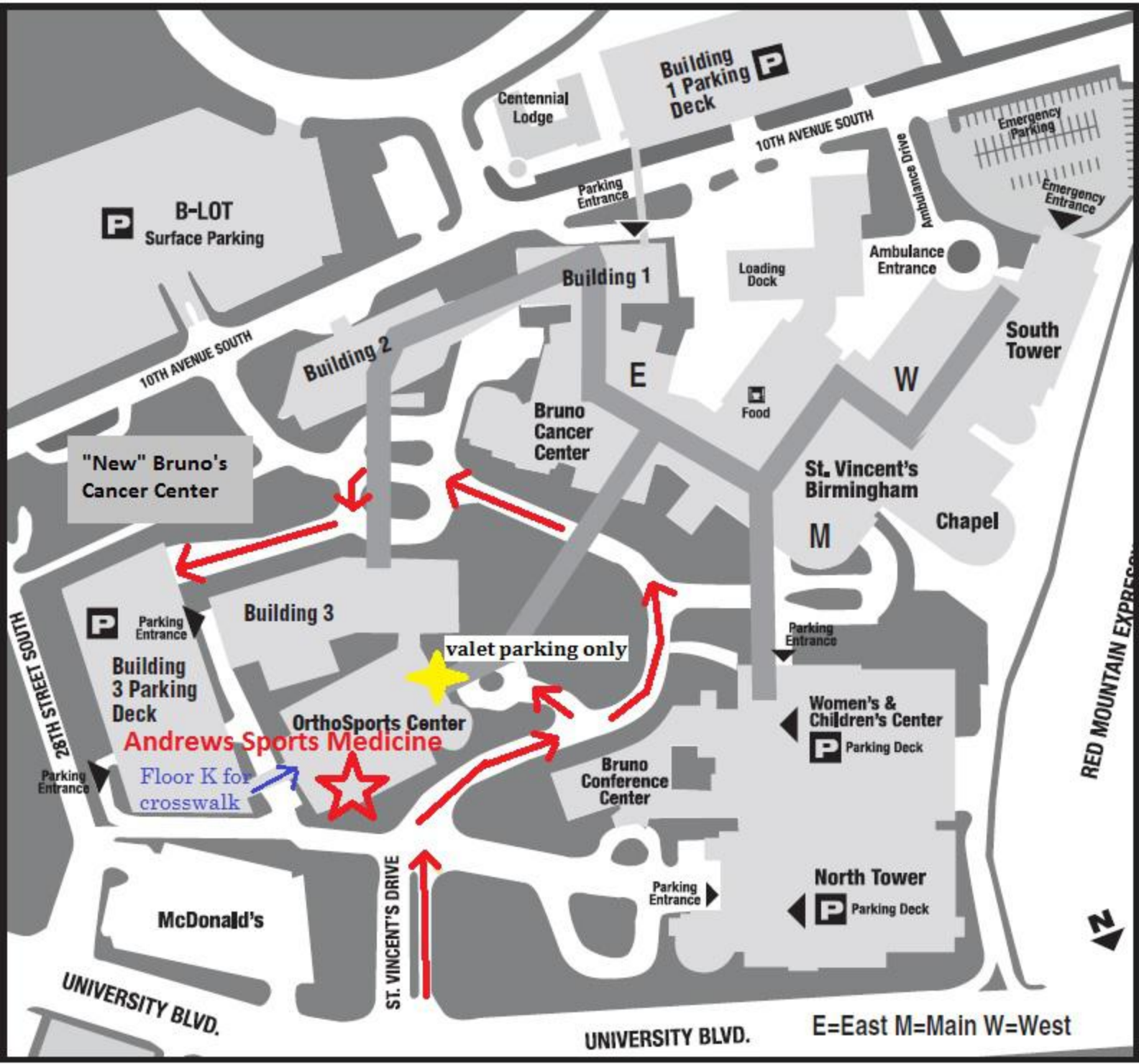
"Andrews Sports Medicine and Orthopaedic Center complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex".

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 14 years of age or over)

Signature of Patient's Personal Representative: _____ Date: ____ / ____ / ____
(If applicable)


Building 1 Parking Deck
Centennial Lodge
10TH AVENUE SOUTH
Emergency Parking
Emergency Entrance
Ambulance Drive
Parking Entrance
B-LOT Surface Parking
Building 1
Loading Dock
Ambulance Entrance
South Tower
10TH AVENUE SOUTH
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
28TH STREET SOUTH
Building 3 Parking Deck
OrthoSports Center
Andrews Sports Medicine
Floor K for crosswalk
Parking Entrance
Women's & Children's Center
Parking Deck
Bruno Conference Center
RED MOUNTAIN EXPRESS
ST. VINCENT'S DRIVE
Parking Entrance
North Tower
Parking Deck
McDonald's
UNIVERSITY BLVD.
UNIVERSITY BLVD.
E=East M=Main W=West