Montgomery SPORTS MEDICINE CENTER

PATIENT REGISTRATION FORM (PLEASE PRINT)

PATIENT'S LAST _____FIRST_____MIDDLE _____

DATE OF BIRTH _____ / _____ / _____ AGE: _____ SEX: M F SOCIAL SECURITY #_____

STREET ADDRESS_____APT #_____

CITY_____ STATE _____ ZIP _____

HOME PHONE _____CELL PHONE _____EMAIL _____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED / SEPARATED

STUDENT: FULL TIME / PART TIME / NOT APPLICABLE

EMPLOYER NAME _____OCCUPATION_____ WORK PHONE _____

EMPLOYER'S ADDRESS_____ STATE_____ ZIP_____

SPOUSE NAME _____OCCUPATION _____ WORK PHONE _____

NEAREST RELATIVE_____RELATIONSHIP_____PHONE_____

PRIMARY PHYSICIAN_____SPECIALTY_____
ADDRESS_____PHONE_____

REFERRING PHYSICIAN_____SPECIALTY_____
ADDRESS_____PHONE_____

HOW DID YOU HEAR ABOUT US?_____

PHARMACY_____**ADDRESS**_____**PHONE**_____

COMPLETE THIS SECTION IF PATIENT IS A MINOR

NAME OF LEGAL GUARDIAN_____RELATIONSHIP_____SS#_____

ADDRESS _____

HOME PHONE _____CELL PHONE_____EMAIL_____

EMPLOYER _____OCCUPATION_____PHONE_____

EMPLOYER'S ADDRESS_____STATE _____ ZIP _____

GUARDIANSHIP FOR MINOR

I, the undersigned, on my behalf or that of a minor under my guardianship _____ (patient/minor name), hereby agree to be financially responsible for the cost of the services that the minor is about to receive. I also understand that if the service(s) are not paid in full at the time of service, I hereby authorize Eran Kessous, MD, PC or their agent to invoice me for any outstanding balances. Executed this _____day of _____, 20_____.

Signature of Guardian_____**Guardian Name**_____**Date**_____

Further, I understand that if the physician(s) do not participate with my insurance plan, I am legally and financially responsible for payment of services rendered.

Signature of Guardian_____**Guardian Name**_____**Date**_____

PATIENT SIGNATURE **DATE**

11120 New Hampshire Ave., Suite 411 • Silver Spring MD 20904
Office (301)754-0505 • Fax (301)754-0509

Montgomery SPORTS MEDICINE CENTER

Appointment Cancellation Policy

Dear Patient,

In order to give you the best possible care, time has been specifically reserved for your physician appointment. In the event you are unable to keep your scheduled time, we ask that you give us a courtesy cancellation notice of 24 hours or more.

If you fail to show up for a scheduled appointment or do not notify the office of a cancellation at least 24 hours in advance, we reserve the right to charge your account the amount of $55.00.

Thank you for your understanding and cooperation.

_____

Print patient name

_____

Signature of patient or Guardian

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INSURANCE INFORMATION (PLEASE PRINT)

PRIMARY INSURANCE CO _____ GROUP # _____ ID # _____

INS CO ADDRESS _____ PHONE # _____

RELATIONSHIP TO INSURED: SELF / HUSBAND / WIFE / CHILD / OTHER: _____

POLICY HOLDER'S INFORMATION (If different from patient)

POLICY HOLDER'S LAST _____ FIRST _____ MIDDLE _____

DATE OF BIRTH _____ / _____ / _____ SEX: M F SOCIAL SECURITY # _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE # _____

EMPLOYER'S ADDRESS _____ STATE _____ ZIP _____

HOME ADDRESS _____ PHONE _____

SECONDARY INSURANCE CO _____ GROUP # _____ ID # _____

INS CO ADDRESS _____ PHONE # _____

POLICY HOLDER'S INFORMATION (If different from patient)

POLICY HOLDER'S LAST _____ FIRST _____ MIDDLE _____

DATE OF BIRTH _____ / _____ / _____ SEX: M F SOCIAL SECURITY # _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE # _____

HOME ADDRESS _____ PHONE _____

IF **WORKER'S COMPENSATION**, DATE OF INJURY _____ CLAIM # _____

NAME OF INSURANCE _____ ADDRESS _____

CONTACT PERSON _____ PHONE # _____

IF **AUTO ACCIDENT**, DATE OF ACCIDENT _____ STATE _____ CLAIM # _____

INS CARRIER _____ POLICY # _____

CONTACT _____ PHONE # _____

PIP FUNDS AVAILABLE: YES / NO / NOT SURE ATTORNEY NAME _____ PHONE _____

ATTORNEY ADDRESS _____

NOTE: PRIMARY INSURANCE INFORMATION IS REQUIRED

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PAYMENT RESPONSIBILITY (PLEASE READ CAREFULLY)

I understand that I have a personal and primary obligation to pay for all medical services when rendered and I agree to pay all bills promptly. I further understand that although Montgomery Sports Medicine Center may submit a bill to my insurance company for payments as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms of my policy. I am aware that insurance payment/ reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding on my account, if such action is deemed necessary. In addition, I agree to pay interest (at 1 ½ % per month) on my outstanding account balance if this balance extends beyond thirty (30) days of receipt of my bill. I agree to pay any additional fees and/or costs incurred in order to collect payments on my account(s). I waive my rights under Maryland's statute of limitation should reconciliation of my account extend beyond three (3) years from date of service.

Please be advised that some insurance carriers have limited or no benefits for durable medical equipment (slings, braces, esthetics, etc). Also, custom made braces are only partially covered by some insurance carriers. We will try our best to confirm your benefits at the time of service, but be aware that you may have a co-insurance that will remain your responsibility. Thanks for your cooperation.

_____**(Please Initial)**

I request the direct payment of authorized medical benefits (including Medicare, Medigap, and major medical benefits) be made to Eran Kessous, MD PC for any services furnished me by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing administration and its agents, to my attorney, or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not paid by the insurance carrier.

Patient/Responsible Party Signature: _____ **Date:**_____

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PATIENT NAME:_____

ASSIGNMENT OF BENEFITS

I authorize payment directly to Montgomery Sports Medicine Center.

This is a direct assignment of my rights and benefits under the Payment Responsibility.

A photocopy of this assignment shall be considered as effective and valid as the original.

RELEASE OF INFORMATION

All information provided herein is true and correct.

I hereby consent to treatment.

I give permission for Montgomery Sports Medicine Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment.

I authorize Montgomery Sports Medicine Center to obtain medical records and/or professional information from my physician and other medical professionals as it relates to my treatment.

Information without patient identifiers may be used for quality assurance purposes.

NOTICE OF PRIVACY PRACTICES (HIPAA Acknowledgement / Consent)

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

I have read the above and understand the information provided. I authorize treatment and the release of information as explained. I approve of the Assignment of Benefits, acknowledge I have received the HIPPA Notice of Privacy Practices and guarantee payment.

Patient or Guardian Signature: _____ **Date:**_____

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HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____

1. Date: _____
2. What is the reason for today's visit? _____
3. Location of symptoms: L /R / Both _____
4. Date symptoms started: _____
5. How symptoms/injury occurred? _____
6. Severity of symptoms better or worse (1-10, 10 being worse?): _____
7. What has made symptoms better or worse? _____
8. List **medical problems** (e.g. asthma, diabetes, high blood pressure): _____
9. List **previous surgeries**: _____ ☐None
10. **Family medical history**: _____ ☐None
11. **Social history**: Do you:
    - **a.** Smoke? Yes ☐ No ☐ _____
    - **b.** Social Drugs? Yes ☐ No ☐ _____
    - **c.** Drink? Yes ☐ No ☐ _____
12. List **current medications**: _____
13. **Allergies** to medications: _____ ☐None

14. **What symptoms are you currently experiencing with any of the below?**
    - a) Eyes: _____ ☐None
    - b) Ear, nose, throat (e.g. runny nose, sore throat)? _____ ☐None
    - c) Heart (e.g. chest pain, palpitations): _____ ☐None
    - d) Respiratory (e.g. difficulty breathing, recent cough): _____ ☐None
    - e) Gastrointestinal (e.g. ulcers, stomach aches): _____ ☐None
    - f) Skin (e.g. skin): _____ ☐None
    - g) Psychiatric (e.g. depression, anxiety): _____ ☐None
    - h) Endocrinologic (e.g. thyroid disease, diabetes): _____ ☐None
    - i) Allergies: _____ ☐None
    - j) Genitourinary (e.g. Incontinence, sexual dysfunction): _____ ☐None
    - k) Musculoskeletal/Rheumatologic (bones, joints): _____ ☐None

15. Height: _____(ft)_____(in) Weight: _____(lbs)

16. Emergency contact _____ Relationship _____ Phone _____
17. What sports do you currently participate in? _____
18. How many days/week do you participate in sports? _____

*Please Note: If prescribed a therapy program, it may include strenuous exercise. If you have any concerns about starting an exercise program, please let us know and check with your regular physician.

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PERSONAL REPRESENTATIVE, FAMILY, FRIENDS OR OTHER ENTITIES AUTHORIZED PERMISSION TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name of specific persons and/or entities that you are authorizing to use and disclose of your protected healthcare information pertaining to treatment payments, billing or other applications of healthcare.

Name of Authorized Person or Entity	Relationship	Phone Number
Name of Authorized Person or Entity	Relationship	Phone Number

Montgomery Sports Medicine Center physicians and staff often contact patients during normal business hours but are unable to reach them. Due to federally mandated HIPAA Privacy Rule, we must obtain your authorization in order to pursue this mode of communication. Protected Healthcare information that may be possibly disclosed on your home, work or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information and appointment instructions.

____ (Initial) Yes, I agree to allow MSMC physicians and staff to leave messages that include Protected Healthcare information on the following communication devices:

home number_____ cell number_____ work number_____

____ (Initial) No, I DO NOT agree to allow MSMC physicians and staff to leave protected healthcare information on any communication devices.

_____

Patient's/Guardian's Signature **Date**

MSMC STAFF ONLY

UNABLE TO OBTAIN HIPPA POLICY ACKNOWLEDGEMENT

I attempted to obtain a signed Notice of Acknowledgement from the patient/guardian, but was unable for the following reason:

_____

_____

_____

MSMC Employee Signature **Date**