



Patient Information

Last Name:	First Name:	Middle Initial:
Address:	City:	State/Zip:
Home Phone:	Work Phone:	Mobile Phone:
Birth date:	Soc Sec #:	(Circle) Male Female
Driver's License:	Other ID:	(Circle) Married Single Child
Employer Name:	Emergency Contact:	
Employer Phone:	Relationship:	Phone:

Insurance Information

	Primary	Secondary
Insurance Company:		
Subscriber Name:		
Relation to Patient (Circle)	Parent Child Self Spouse Other	Parent Child Self Spouse Other
Subscriber Birth Date:		
Subscriber Social Security Number:		
Policy Number:		
Group Number:		
Insurance Address:		
Insurance Phone Number:		

New Injury Summary

What Body Part Hurts? (Circle) Right Left Both	Date of injury?	What would you like to have done today?
How often do you have pain?	How long does the pain last?	
Have you injured this area before?	Have you had it evaluated before?	
If yes, when?	If yes, what did they tell you was wrong?	
Circle your Symptoms: Swelling Grinding Numbness Chills Tingling Fever Instability Catching Locking Weakness Redness	Circle Your Treatments: Ibuprofen (Advil, Motrin) Tylenol Ice Heat Surgery injection(s) Physical Therapy Other: _____	

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

I hereby consent to the Notice of Privacy Practices currently in force by OUCH Sports Medical Center. I certify by my signature that I have read and understand the information disclosed in the above referenced notices. I also understand that changes to this notice can be made at any time, and that it is the patient's responsibility to remain current on those changes. A copy of the current Notice of Privacy Practices will be available for inspection at the reception desk at all times, and copies of the current notice can be obtained at no charge, upon request.

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION

I, the undersigned, have insurance coverage as stated above and directly assign all medical benefits to OUCH Sports Medical Center for services rendered by the physicians or other medical providers under their supervision. I also understand that I am financially responsible for all charges. I hereby authorize OUCH Sports Medical Center to release all information necessary to obtain payment of insurance benefits. I authorize the use of this signature on all insurance claims submitted on my behalf. I consent for care and treatment as required by the physician. I understand that there is a charge of \$40.00 for all returned checks.

DME & SUPPLIES UNDERSTANDING

I understand that I will be responsible for all supplies and other medically necessary equipment, prescribed and/or distributed by my physician that my insurance plan does not cover.

Signature of Patient/Insured/Guarantor

Date MM/DD/YYYY



New Patient History

Patient Name:	
List all medical problems (i.e. diabetes, hypertension):	
List surgeries you have had:	
List all prescription medications, including dose and frequency:	
List all vitamins/supplements, including dose and frequency:	
Do you have any medication or food allergies ? If yes, describe:	
List significant family history of medical problems (i.e. mother with breast cancer):	
Do you smoke? If yes, for how many years?	
Do you drink alcohol? If yes, how much/how often?	
Social history:	(circle) Married Single Other
Heart symptom(s); circle any you are experiencing currently:	chest pain, arm pain, fainting, dizzy, palpitations, swollen feet, other
Lung symptom(s); circle any you are experiencing currently:	shortness of breath, coughing, wheezing, tightness, low exercise tolerance, other
Stomach Symptom(s); circle any you are experiencing currently:	abdominal pain, nausea, vomiting, diarrhea, heartburn, weight loss, decreased appetite, other
Thyroid symptom(s); circle any you are experiencing currently:	heat/cold intolerance, fatigue, weight gain/loss, swelling, other
Kidney symptom(s); circle any you are experiencing currently:	pain or burning with urination, frequency, hesitancy, blood in urine, other
Neurological symptom(s); circle any you are experiencing currently:	tingling, numbness, weakness, loss of speech, imbalance other

How did you hear about **Ouch Medical Center** (circle)?

Friend Newspaper School Coach School Physical Exam
Walk-in Insurance Provider Internet Athletic Trainer Other

Signature of Patient/Insured/Guarantor

Date MM/DD/YYYY



sports medical center

Contract of Agreement

For Payment of Services Rendered

(Please initial the areas that pertain to you)

Name of Patient: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship: _____

I, _____, understand that I am responsible for all services performed, for the above named patient or myself, at OUCH Medical Center.

_____ **I have insurance coverage:** I will provide complete and correct information to OUCH Medical Center to assist in ensuring that my insurance pays for all services rendered. If any conflicts arise regarding payment on services, I agree to contact my insurance company to resolve the conflict upon notification.

_____ **I have a work related injury/illness:** I will provide complete and correct information to ensure the Worker's Comp. Insurance pays for my services. I understand that unless authorization for treatment has been obtained from my employer, I am responsible for payment of all services rendered at OUCH Medical Center. If any conflicts arise regarding payment on my claims, I agree to contact my employer and their insurance provider to resolve the conflict upon notification.

_____ **Legal Lein:** If my case is turned over to a lawyer for a lein, I understand that OUCH Medical Center does not accept leins and that I am responsible for payment of all services rendered.

_____ **I have no insurance:** I am presenting for services without any insurance coverage and I understand that payment for services is due upon the completion of my visit today unless prior arrangements have been agreed upon by OUCH Management and myself in writing.

_____ **Third party billing:** I am presenting for services that are to be paid by someone other than myself or an insurance company. I understand that OUCH Medical Center does not bill Third Parties without written consent and a verbal confirmation. I understand that I am responsible for all services rendered at OUCH Medical Center and if any conflict arises regarding payment, I agree to contact the payor to resolve the conflict upon notification. I understand that I am ultimately responsible for the payment of all services.

_____ **Auto Insurance:** I am presenting for services that are covered by an Auto Insurance Claim. I understand that OUCH Medical Center does not accept auto insurance claims and that I am responsible for all services performed at OUCH Medical Center and that I will file my own claims for reimbursement with the insurance company.

Durable Medical Equipment (DME) / Supplies: I understand that some insurance companies or specific plans do not cover all DME or supplies that are distributed from a physician office and that I am responsible for ensuring that these items are covered by my insurance plan or by myself.

NOTICE: Photo identification is required to ensure the identity of our patients and to protect them from fraud. I understand that OUCH Medical Center requires a copy of my photo identification or drivers license to be kept in my chart for identification purposes only. If I refuse to allow them to copy my identification, I will provide the identification card number and present the card for verification as requested.

Signature of Patient/Insured/Guarantor

Date MM/DD/YYYY