Sports Medicine Associates of South Florida P.A.

□ Alfred A. DeSimone, M.D., Orthopaedic Surgeon
□ Fernando A. Moya, M.D., Orthopaedic Surgeon
□ Alexander J. Bertot, M.D., Orthopaedic Surgeon
□ David Shenassa, M.D., Hand Surgeon
□ Franz Jones, D.O., Physiatrist

□ 1600 Town Center Blvd. Weston, FL 33326 (954) 389-5900
□ 17842 N.W. 2nd St., Pembroke Pines, FL 33029 (954) 430-9901
□ 220 S.W. 84 Avenue, Plantation, FL 33324 (954) 720-1530

PATIENT INFORMATION

PLEASE PRINT

Date _____

First Name _____ Middle _____ Last Name _____ Martial Status _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Email _____
Date of Birth _____ Age _____ Sex _____ SS No. (last four digits) _____
Driver License Number _____ State _____
Race (optional) _____ Ethnicity (optional) _____ Preferred Language _____
If patient is a minor – please complete:
Father's Name _____ Phone _____
Mother's Name _____ Phone _____
Please list the name of a person to contact in case of emergency:
Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE

Name of Company _____ Telephone _____
Insured Full Name _____ Date of Birth _____
Member ID Number _____ Group Number _____
Relationship to Insured (self, spouse, child, other) _____

SECONDARY INSURANCE (if applicable)

Name of Company _____ Telephone _____
Insured's Full Name _____ Date of Birth _____
Member ID Number _____ Group Number _____
Relationship to Insured (self, spouse, child, other) _____

FOR MOTOR VEHICLE ACCIDENTS ONLY (Related to this visit)

Date of Accident _____ Describe Injury _____
Insurance Carrier _____ Phone _____
Fax _____
Claim Number _____ Adjuster Name _____
Do you have an attorney □ No □ Yes
If Yes, Name _____ Phone _____
Fax _____

FOR WORKER'S COMPENSATION ONLY (Related to this visit)

Date of Accident _____ Describe Injury _____
Insurance Carrier _____ Phone _____
Adjuster Name _____ Phone _____
Case Manager _____ Phone _____

Do you have an attorney □ No □ Yes Fax _____
If Yes, Name _____ Phone _____

FOR WORKER'S COMPENSATION INJURIES ONLY. You must report your injury to your employer and they must then report it to their insurance carrier. If we do not receive worker's compensation forms to fill out within 60 days, you will be billed and held responsible for payment.

Patient or Minor's Legal Guardian's Signature _____ **Date** _____

Medical History

Primary Care Doctor _____ Phone No _____ Date of Last Exam_____
Describe the condition that brought you to this office_____
_____
Have you had previous care for this condition □ Yes □ No Dr._____ Date _____
Whom may we thank for referring you to us □ Patient _____
□ Doctor _____ □ Other _____

Medical: (Please check any of the following if it pertains to you):

□ Diabetes □ Heart Attack □ Seizures □ Asthma □ High Blood Pressure
□ Angina/Chest Pain □ Hiatal Hernia □Thyroid Disorder □ Angioplasty □ Hepatitis
□ Kidney Disorder □ Bleeding Disorders □ Stroke/TIA's □ Ulcers □ Cirrhosis
□ Mitral Valve Prolapse □ Circulation Disorder □ Anemia □ Human Immunodeficiency Virus (HIV)
□ Other: _____

Allergies:

□ No known allergies □ Penicillin □ Aspirin □ Codeine □ Latex □ Iodine □ Tape
Other: _____

Medications: (Please include prescribed and over-the-counter medications) □ None

Current Medication	Dose	Frequency

List all previous Surgeries □ None

Type of Surgery	Year

Previous Surgeries & Hospitalizations:
Family History: □ Diabetes □ High Blood Pressure □ Bleeding Tendencies □ Other _____
Social History: □ Smoking □ Alcohol □ Recreational Drugs

Do you suffer from any of the following:

□ Neck Pain (cervical discogenic pain)
□ Shoulder pain (rotator cuff tendonitis)(impingement)
□ Shoulder (rotator cuff) tear
□ Tennis Elbow / Golfer's Elbow
□ Carpal Tunnel Syndrome (numbness and tingling)
□ Hip or knee arthritis
□ Knee instability or looseness (ACL ligament tear)
□ Lower back pain
□ Shoulder instability (labral tear) (dislocation)
□ Bursitis (shoulder, elbow, hip or knee)
□ Chronic wrist pain
□ Trigger finer (catching or locking fingers)
□ Knee pain and swelling (cartilage or meniscal tear)
□ Knee cap (patella) instability (subluxation)

Review of Systems

Patient: _____ **Date:** _____

Do you now or have you had any problems related to the following systems? Circle Yes or No

General			**Genitourinary**		
Weight Loss	Y	N	Pain while urinating	Y	N
Weight Gain	Y	N	Burning while urinating	Y	N
Fever / Chills	Y	N	Blood in urine	Y	N
Difficulty Sleeping	Y	N	Hesitancy in urinating	Y	N
			Incontinence	Y	N
Head, Eyes, Ears, Nose, Throat			Night time urinating	Y	N
Change in Vision	Y	N			
Ear Infection or drainage	Y	N	**Musculoskeletal**		
Sinus infections	Y	N	Arthritis	Y	N
Problems swallowing	Y	N	Muscle weakness	Y	N
Glaucoma	Y	N	Frequent fractures	Y	N
Cataracts	Y	N	Osteoporosis	Y	N
Impaired hearing	Y	N	Joint stiffness	Y	N
Cardiovascular			**Neurological**		
Chest pain (angina)	Y	N	Mini strokes	Y	N
Shortness of breath	Y	N	Strokes	Y	N
Heart Murmur	Y	N	Seizures	Y	N
Difficulty walking 2 blocks	Y	N	Fainting Spells	Y	N
Palpitations	Y	N	Headache / Migraine	Y	N
Dizziness	Y	N			
Swelling of the feet	Y	N	**Endocrine**		
Blood Clots	Y	N	Hypothyroidism	Y	N
			Hyperthyroidism	Y	N
Pulmonary			Diabetes (insulin dependent)	Y	N
Cough	Y	N	Diabetes (Oral medication)	Y	N
Snoring	Y	N			
Sputum production	Y	N	**Skin**		
Emphysema/COPD	Y	N	Rashes	Y	N
Asthma	Y	N	Jaundice	Y	N
Sleepiness during the day	Y	N	Skin cancer	Y	N
Gastointestinal					
Heartburn	Y	N			
Change of Appetite	Y	N			
Frequent vomiting	Y	N			
Change in bowel habits	Y	N			
Black, tarry stools	Y	N			
Rectal bleeding	Y	N			

Sports Medicine Associates of South Florida P.A.

I understand that I am responsible for the cost of the professional medical services provided to me by Sports Medicine Associates of South Florida, P.A. ("Sports Medicine") regardless of the availability of certain other sources of payment, including insurance benefits and pending claims I may have against third parties who may be responsible for my medical condition. I elect to pay for the professional services provided by Sports Medicine as follows:

Check on of these if this is a legal case:	**Check one of these if this is NOT a legal case:**
☐ I have a Third Part Claim (defined below) and intend to seek compensation from a third party. I have engaged an attorney and will sign, with my attorney, a Letter of Protection in favor of Sports Medicine. If PIP insurance is available a claim may be submitted to the applicable PIP insurance company. I will not use any health insurance or Medicare benefits. I understand my charges may exceed the benefits available from my PIP insurance, and I am responsible for payment of all charges to the fullest extent. ☐ Self-Pay. I will be personally responsible for all charges by Sports Medicine.	☐ I intend to use available health insurance benefits, as applicable, subject to coordination of benefits rules applicable to these policies and benefit programs. ☐ I intent to use any available PIP benefits. Once exhausted, I will personally be responsible for all remaining balances. ☐ Self-pay. I will be personally responsible for all charges by Sports Medicine.

Accordingly, in consideration for the medical services rendered by Sports Medicine and its physician, I agree to the following terms and conditions:

1. **Guarantee of Payment**: I guarantee prompt payment of all such services not otherwise paid by insurance or any third party. Payment for any services provided to me is not contingent upon the receipt of any aware of damages or payment upon any claim I may make against a third party.
2. **Health or PIP Insurance**: If I am entitled to and intend to utilize health insurance, Medicare, or PIP Insurance coverage for the services rendered to me by Sports Medicine, I understand that coinsurance and deductible amounts are due and payable at the time that professional services are rendered. Upon the exhaustion of the above benefits, I understand that I am responsible for all charges in excess of such exhausted benefits to the extent permitted by law, which charges, together with charges for services which are not covered shall be payable at the time that professional services are rendered. I acknowledge that Sports Medicine's charges may exceed the benefits available from my PIP and health insurance policies and that I am responsible for the payment of such charges to the fullest extent permitted by law.
3. **Authorization**: I hereby authorize any and all assigned insurance companies to pay the amount due in any pending claims directly to Sports Medicine. I understand that, unless otherwise required by law, any amounts not covered or not paid by my insurance policy or any third party payer, including charges for services which are not covered benefits under my insurance policy, are my personal responsibility. If any action at law or in equity is brought to enforce this agreement, Sports Medicine and/or treating physicians shall be entitled to recover attorney's fees, court costs, and any other costs of collection incurred., Sports Medicine will not balance bill where prohibited by law.
4. **Third Party Claims:** If I seek, or intend to seek, the recovery of monetary damages in connection with an accident or other tort claim from a third party ("third Party Claim"), I must provide a Letter of Protection, subject to the approval of Sports Medicine, that is duly signed by me and my legal counsel ("LOP"). According to the LOP, sports Medicine will accept payment of professional fees upon settlement or final judgement in my case. I understand that, if there is no settlement, or if I otherwise receive no payment in consideration of my Third Part Clam I am fully responsible for the professional fees charged by Sports Medicine, which fees shall be due and payable immediately upon the earlier to occur of the following: (1) final judgement against me or dismissal of my Third Party Claim, or (2) the abandonment of my Third Part Claim by me or my legal counsel.
5. **No Insurance Benefits:** If I have no insurance and there is no third party payer available to pay for Sports Medicine's professional services. I understand that payment is due at the time professional services are rendered.**I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND THAT I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.**

Patient Name (Print) _____ **Date** _____

Patient Signature or Authorized Representative _____

Relationship to Patient _____

Sports Medicine Associates of South Florida, P.A.
Company Policies

Please initial each line

Notice of Privacy Practices (HIPPA)

_____ I acknowledge I have received a copy of Sports Medicine Associates of South Florida Notice of Privacy Practices.

Medical Information Release

I authorize the physician of SMASF to release any information including diagnosis acquired in the course of my exam to any health
_____ care facilities, physicians, insurance carriers, or collection agencies.

Assignment of Benefits

I authorize my insurance carrier to pay directly to Sports Medicine Associates of South Florida, PA the medical benefits otherwise payable to me for their services, but not exceed the charges of those services. I further understand that I am fully responsibility for services provided that are not covered by my insurance. I hereby irrevocable assign to Sports Medicine Associates of South Florida, PA any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the
_____ Florida statutes for any service and/charges provided by SMASF.

Communication

The staff at Sports Medicine Associates of South Florida, PA is authorized to call me at these numbers. I agree to receive emails and texts to the numbers listed on file and understand I may be subject to the text messaging rates of my cellular plan. If I am not
_____ available they are permitted to leave a message with whomever answers or an answering machine / voice mail.

Patient Financial Responsibility

As a courtesy to our patients, Sports Medicine Associates of South Florida, PA verifies insurances in advance. However, it is ultimately the patient's responsibility to be aware of all co-payments, co-insurances, and deductibles; Any quote of patient responsibility by SMASF is an **estimate** and may not reflect the actual amount due from the patient for services rendered. Any additional amounts due will be billed to the patient upon receipt of the EOB from the insurance company. These amounts are solely the patient's responsibility, regardless of any quote previously provided by Sports Medicine Associates of South Florida, PA.

It is the policy of this office to collect all co-payments, deductible, and co-insurance indicated as the patient's responsibility by their insurance company. We can not waive or reduce any patient's responsibility as per our contract with your insurance company.

It is the policy of this practice to charge a $35.00 **no show fee** for any appointments missed and not canceled or reschedule 24 hours in advance to the appointment time. I understand the above and that I am responsible to cancel or reschedule my appointments 24 hours in advance or pay the $35.00 No Show fee for missed appointments. I understand the above and that I am
_____ solely responsible for any amounts deemed due by me according to my insurance plan and agree to pay promptly.

Consent for Treatment

I consent to and authorize a physician and /or health care professional of Sports Medicine Associates of South Florida, PA to perform a physical examination, procedures, diagnostic procedure, and to prescribe a therapeutic regimen. I acknowledge implicit permission for SMASF to import my prescription history from the medication / pharmacy databased into my account when an
_____ appointment was made on my behalf.

Medical Record Request

Medical record requests need to be made in advance. Please contact **ShareCare at 866-602-5677** or obtain a request form at
_____ the office.

X-Ray Copies

Request for x-ray CD copies need to be made and paid in advance. It will take approximately one (1) business day for the copies. There is a $15.00 fee per x-ray CD that will need to be collected prior to making copies. We will not make copies unless they are
_____ paid for in advance.

Sports Medicine Associates of South Florida complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or any other protected class.

Records Release

By my signature below, I hereby authorize the release of my diagnostic imaging results, medical records, hospital records, consultations, lab work, or any other pertinent medical information from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form to Sports Medicine Associates of South Florida.

_____ _____ _____

Name (Print) **Signature** **Date**

_____

Date of Birth

SPORTS MEDICINE ASSOCIATES OF SOUTH FLORIDA P.A.

NOTICE OF PRIVACY PRACTICES

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices
We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure
This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication
This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone, text messaging), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI
This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI
This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information
This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability
This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice
You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.
If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment
We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices
We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment
Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.
Healthcare Operations
We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.
Health Information Organization
The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures
We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

We will not retaliate against you for filing a complaint.

Sports Medicine Associates of South Florida, P.A.
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