



DATE: _____ Office use only: L M C S Cr G

REFERRED BY: _____
(MD/Coach/Trainer/Friend, etc)

CURRENT SPORT: _____ TEAM/SCHOOL: _____

PATIENT: _____
(LAST NAME) (FIRST NAME) (M.I.) (Preferred name)

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DOB: _____ AGE: _____ SEX: M F Social Security Number # _____

CELL PHONE: _____ WORK PHONE: _____ HOME PHONE: _____

PATIENT EMPLOYER: _____

MARITAL STATUS: _____ PATIENT IS A STUDENT: Full-time Part-time

HOW YOU WOULD LIKE RECEIVE APPOINTMENT REMINDERS Cell Call Cell Text EMAIL Home phone

PATIENT/GUARDIAN'S EMAIL ADDRESS: _____
(EMAIL MUST BELONG TO PATIENT IF 18+ YEARS OF AGE OR PARENT/GUARDIAN IF MINOR)

ETHNICITY: Hispanic or Latino Non-Hispanic or Latino PREFERRED LANGUAGE: _____

Race: American Indian OR Alaskan Native Asian Black/African American White Native Hawaiian OR Pacific Islander

Emergency Contact: Name: _____ Relationship: _____ Phone Number: _____

Is the patient the policyholder for insurance? Y N if No, please complete below policyholder info.

Please complete for insurance policy holder.

Relationship to patient: _____ Name: _____

DOB: _____ SSN: _____

Employer: _____ Cell phone: _____ Work phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____
Indicate if same as patient or please complete address line above.

Insurance Company Name Policy ID# Group#

Please complete for secondary insurance policyholder or responsible adult if patient is a minor.

Relationship to patient: _____ Name: _____

DOB: _____ SSN: _____

Employer: _____ Cell phone: _____ Work phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____
Indicate if same as patient or please complete address line above.

Insurance Company Name Policy ID# Group#

Please complete for Workers Compensation insurance or Motor Vehicle insurance.

Insurance Company Name and Address Claim Number Phone and Name for Agent or Representative

***SIGN HERE: _____ DATE: _____



PATIENT: _____

The information presented here enables you to consent for needed medical services, as well as for the release of information from your medical records for medical and administrative purposes.

CONSENT FOR TREATMENT: I am presenting myself for outpatient care at Idaho Sports Medicine Institute, PA and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by authorized agents and employees of Idaho Sports Medicine Institute, PA and by medical staff or their designees as in their professional judgment may be deemed necessary. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic. *Initial* _____

HIPAA ACKNOWLEDGEMENT: I hereby acknowledge that I have received a copy of the Idaho Sports Medicine Institute, PA Notice of Privacy Practices on this date or on a previous date. *Initial* _____

RELEASE OF INFORMATION: I authorize ISMI to release any information from my medical record, including information about my treatment to a third party payer or a designated review agency for the purpose of processing my claim. *Initial* _____

PAYMENT AGREEMENT: All services rendered are charged to the patient. We will file your claim if you have supplied us with insurance information in a timely manner. Co-pays, deductible or percentage amounts are due at the time of service unless advance arrangements have been made with ISMI. Monthly statements will be mailed to you and payment is 60 days or older may be transferred to and administrated by Account Billing Services (ABS). ABS will set up a payment plan with you and charge monthly interest. If litigation must be instituted to collect your account then you agree to pay all of the reasonable attorney fees and court costs incurred in collecting the amount due. *Initial* _____

MISSED APPOINTMENTS: Broken appointments or late notice cancellations are a significant cost to the practice. Cancellations are requested 24 hours prior to the appointment to give us the time to offer the time slot to another patient. We reserve the right to charge \$50.00 for missed appointments. *Initial* _____

HOSPITAL OWNERSHIP DISCLOSURE: As a patient of Idaho Sports Medicine Institute, your physician may order tests or schedule procedures that are performed at local hospitals. These include (but are not limited to) laboratory tests, x-rays, CT scans, MRIs, injections, and surgical procedures. Some of the physicians at Idaho Sports Medicine Institute are investors at Treasure Valley Hospital, which is one of the local hospitals that provide these services. Our physicians also practice at St Alphonsus and St Luke's where they do not have an ownership interest. This information is to confirm that you understand, as a patient of Idaho Sports Medicine Institute, you have the right to choose the hospital where you would like to receive your services. *Initial* _____

ASSIGNMENT OF BENEFITS (NON-MEDICARE): I hereby authorize payment directly to Idaho Sports Medicine Institute, PA of all healthcare benefits, not to exceed charges, to which I would otherwise be entitled for these services. I agree that the cumulative payments received by ISMI from all sources shall be applied to pay the entire charge for ISMI's medical services without reduction in charges whatsoever for plan adjustments in order that ISMI is paid in full for such services if and when the undersigned has multiple insurance policies or coverage's for the medical services being provided by ISMI and the applicable insurance policies or coverage's do not coordinate the payment of benefits for such services. I understand that I am responsible for any and all balances owing.

Patient Signature _____ **Date/Time** _____

ASSIGNMENT OF BENEFITS (MEDICARE ONLY): I request that payment of authorized Medicare benefits be made on my behalf to Idaho Sports Medicine Institute, PA for any services furnished to me by their providers. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents to determine these benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it.

Patient Signature _____ **Date/Time** _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND DO VOLUNTARILY AGREE TO ITS PROVISIONS.

Patient _____ **Date:** _____

Responsible _____ **Relationship** _____

(PATIENT MUST BE 18 YEARS OR OLDER TO SIGN. PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE)

Patient Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Chief Complaint/Reason for visit: R L _____

Is your current problem the result of an injury? No Yes

If **YES**, how did it happen? Car Accident Work Accident Other: _____

Date of Injury/Onset of pain: _____

How severe is the pain on a scale of 1-10? (Circle One): None 1 2 3 4 5 6 7 8 9 10 Severe

Type of pain (circle all that apply): Sharp Dull Pins/Needles Aching Cramping Stabbing Throbbing Constant Intermittent

Pharmacy Name and Location: _____

Patient Medical History

	Past	Current		Past	Current
Asthma			HIV or AIDS		
Atrial Fibrillation			Kidney Disease		
Bleeding Tendencies			Liver Problems		
Blood Clots or DVT			MRSA		
Cancer			Rheumatoid Arthritis		
Concussion			Osteoarthritis		
COPD			Osteoporosis		
Diabetes Type I			Seizure Disorder		
Diabetes Type II			Sleep Apnea		
Emphysema			Stomach Ulcer		
Fibromyalgia			Thyroid Disease		
Hepatitis			Other:		
High Blood Pressure			Other:		
			<input type="checkbox"/> No Known Medical History		

Patient Surgical History

Body Part	Side (Please Circle)	Date/Year	Procedure
Shoulder	R L		
Arm	R L		
Chest	R L		
Torso	R L		
Hip	R L		
Knee	R L		
Leg	R L		
Ankle	R L		
Foot	R L		

Other (Please list/describe):

Patient's Social History

Occupation: _____

What is your dominant side? RIGHT LEFT

Sports & Fitness Activities (please list): _____

Please answer the following questions:

	Current Every Day User	Current Some Day User	Former User	Never User
Do you drink alcohol?				
Do you consume caffeine?				
Do you use recreational drugs?				
Do you smoke, vape, or chew? (Circle)				

Patient's Family History

	Father	Mother	Brother	Sister
Anesthesia Problems				
Bleeding Problems				
Blood Clots				
Cancer (please specify)				
Diabetes Type I				
Diabetes Type II				
Gout				
Heart Disease				
Osteoporosis				
Pulmonary Embolism				
Rheumatoid Arthritis				
Other:				
<input type="checkbox"/> Family History Unknown				
<input type="checkbox"/> Adopted				

Medications you are taking (include over-the-counter, vitamins, supplements, etc):

Medication	Strength	Route (Mouth, Inj., etc.)	How much do you take (dosage)?	How often?
<input type="checkbox"/> Taking no medication at this time				

Allergies:

	List Allergy and Reaction
Medication?	
Latex, Sutures, Tape, Metal, Jewelry	
Other (list):	
<input type="checkbox"/> No allergies at this time	

SIGN HERE: _____

DATE: _____

(PATIENT MUST BE 18 YEARS OR OLDER TO SIGN; PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE)