PERSONAL & DEMOGRAPHIC INFORMATION

APPT DATE		ACCT NO.	

PATIENT INFORMATION
INFORMACIÓN DEL PACIENTE

LAST NAME *APELLIDO(S)*		FIRST NAME *PRIMER NOMBRE*		MIDDLE NAME *SEGUNDO NOMBRE*	
SEX *SEXO*		DATE OF BIRTH *FECHA DE NACIMIENTO*		SOCIAL SECURITY NO. *NO.DE SEGURO SOCIAL*	

MARITAL STATUS *ESTADO CIVIL*
- ❑ **Single** *Soltero*
- ❑ **Life Partner** *Unión Libre*
- ❑ **Legally Separated** *Legalmente Separado*
- ❑ **Married** *Casado*
- ❑ **Divorced** *Divorciado*
- ❑ **Widowed** *Viudo*

TITLE *TITULO*
- ❑ **Mr.** *Sr.*
- ❑ **Mrs.** *Sra.*
- ❑ **Ms.** *Srta.*
- ❑ **Dr.** *Dr.*

RACE *RAZA*
- ❑ **Asian** Asiático
- ❑ **Black** Negro
- ❑ **White** Blanco
- ❑ **American Indian or Alaskan Native** *Indígena Americano o Originario de Alaska*

ETHNICITY *ETNICIDAD*
- ❑ **Hispanic or Latino** Hispano o Latino
- ❑ **Not Hispanic or Not Latino** *No Hispano o No Latino*

PREFERRED LANGUAGE LENGUAJE PREFERIDO
- ❑ **English** *Ingles*
- ❑ **Spanish** *Español*
- ❑ **Other** *Otro* _____

MAILING ADDRESS *DOMICILIO DE ENVIÓ*					
CITY *CIUDAD*		STATE *ESTADO*		ZIP CODE *CÓDIGO POSTAL*	
PRIMARY TEL *TEL PRINCIPAL*		SECONDARY TEL *TEL SECUNDARIO*		ALTERNATE TEL *TEL ALTERNATIVO*	

_____ INITIAL *INICIALES*
I <u>authorize</u> POSM staff to leave information on my answering machine or voicemail
Yo doy mi <u>autorización</u> para que el personal de POSM deje mensaje en la contestadora o correo de voz.

_____ INITIAL *INICIALES*
I <u>DO NOT</u> authorize POSM staff to leave information on my answering machine or voicemail
Yo <u>NO</u> doy mi autorización para que el personal de POSM deje mensaje en la contestadora o correo de voz.

OCCUPATION *OCUPACIÓN*		EMPLOYER'S / SCHOOL'S NAME *NOMBRE DE EMPLEADOR / ESCUELA*		WORK TEL *TEL TRABAJO*	

EMPLOYMENT STATUS *ESTADO DE EMPLEO*
- ❑ **Full-Time** Tiempo Completo
- ❑ **Part-Time** Tiempo Parcial
- ❑ **Unemployed** Desempleado
- ❑ **Retired** Retirado
- ❑ **Student F/T** Estudiante T/C
- ❑ **Student P/T** Estudiante T/P

EMERGENCY CONTACT INFORMATION
INFORMACIÓN DEL CONTACTO DE EMERGENCIA

LAST NAME *APELLIDO(S)*		FIRST NAME *PRIMER NOMBRE*		MIDDLE NAME *SEGUNDO NOMBRE*	
RELATIONSHIP TO PATIENT *PARENTESCO CON EL PACIENTE*				TEL *TEL*	

ACCOUNT GUARANTOR INFORMATION (For Minors)
INFORMACIÓN DEL PERSONA RESPONSABLE DE LAS FACTURAS (Para Menores de Edad)

LAST NAME *APELLIDO(S)*		FIRST NAME *PRIMER NOMBRE*		MIDDLE NAME *SEGUNDO NOMBRE*	
SEX *SEXO* ❑ **Male** *Masculino* ❑ **Female** *Femenino*		DATE OF BIRTH *FECHA DE NACIMIENTO*	/ /	SOCIAL SECURITY NO. *NO. DE SEGURO SOCIAL*	- -

RACE *RAZA*
- ❑ **Asian** Asiático
- ❑ **Black** Negro
- ❑ **White** Blanco
- ❑ **American Indian or Alaskan Native** *Indígena Americano o Originario de Alaska*

ETHNICITY *ETNICIDAD*
- ❑ **Hispanic or Latino** Hispano o Latino
- ❑ **Not Hispanic or Not Latino** *No Hispano o No Latino*

PREFERRED LANGUAGE LENGUAJE PREFERIDO
- ❑ **English** *Ingles*
- ❑ **Spanish** *Español*
- ❑ **Other** *Otro* _____

PRIMARY TEL *TEL PRINCIPAL*		SECONDARY TEL *TEL SECUNDARIO*		ALTERNATE TEL *TEL ALTERNATIVO*	

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REFERRAL SOURCE
FUENTE DE REMITENCIA

Who referred you? *¿Quién lo remitió?*	❑ **Hospital** *Hospital* _____	❑ **Physician** *Medico*	❑ **Family/Friend** *Familiar/Amigo*	❑ **Phone Book** *Directorio Tel*	❑ **Insurance Co.** *Co. de Seguro*	❑ **Other** *Otro* _____

PHYSICIAN'S NAME *NOMBRE DEL MEDICO*		**OFFICE TEL** *TEL DE OFICINA*	
OFFICE ADDRESS *Domicilio de Oficina*			
CITY, STATE, ZIP CODE *CIUDAD, ESTADO, CODIGO POSTAL*			

PRIMARY INSURANCE INFORMATION
INFORMACIÓN DE SEGURO PRIMARIO

CARRIER *ASEGURADORA*		**POLICY NO.** *NO. DE PÓLIZA*		**GROUP NO.** *NO. DE GURPO*	
POLICY HOLDER NAME *NOMBRE DEL PORTADOR DE PÓLIZA*					
SEX *SEXO*	❑ **Male** *Masculino* ❑ **Female** *Femenino*	**DATE OF BIRTH** *FECHA DE NACIMIENTO*	/ /	**SOCIAL SECURITY NO.** *NO.DE SEGURO SOCIAL*	- -
RELATIONSHIP TO PATIENT *PARENTESCO CON EL PACIENTE*		**EMPLOYER** *EMPLEADOR*			

SECONDARY INSURANCE INFORMATION
INFORMACIÓN DE SEGURO SECUNDARIO

CARRIER *ASEGURADORA*		**POLICY NO.** *NO. DE PÓLIZA*		**GROUP NO.** *NO. DE GURPO*	
POLICY HOLDER NAME *NOMBRE DEL PORTADOR DE PÓLIZA*					
SEX *SEXO*	❑ **Male** *Masculino* ❑ **Female** *Femenino*	**DATE OF BIRTH** *FECHA DE NACIMIENTO*	/ /	**SOCIAL SECURITY NO.** *NO.DE SEGURO SOCIAL*	- -
RELATIONSHIP TO PATIENT *PARENTESCO CON EL PACIENTE*		**EMPLOYER** *EMPLEADOR*			

TERTIARY INSURANCE INFORMATION
INFORMACIÓN DE SEGURO TERCIARIO

CARRIER *ASEGURADORA*		**POLICY NO.** *NO. DE PÓLIZA*		**GROUP NO.** *NO. DE GURPO*	
POLICY HOLDER'S NAME *NOMBRE DEL PORTADOR DE PÓLIZA*					
SEX *SEXO*	❑ **Male** *Masculino* ❑ **Female** *Femenino*	**DATE OF BIRTH** *FECHA DE NACIMIENTO*	/ /	**SOCIAL SECURITY NO.** *NO.DE SEGURO SOCIAL*	- -
RELATIONSHIP TO PATIENT *PARENTESCO CON EL PACIENTE*		**EMPLOYER** *EMPLEADOR*			

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS: If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Insurance payment for the services rendered cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

AVISO CON RESPETO A LOS RECLAMOS / FACTURAS / PAGOS DE COMPAÑÍA DE SEGURO: *Si vamos a remitir su factura al seguro necesitamos que nos de toda la información necesaria, incluyendo la renitencia de su médico de cabecera cuando el seguro lo requiere. Si usted no puede proveer toda la información requerida/necesaria no podremos remitir la factura al seguro, y usted será responsable de cubrir el costo completo de los servicio que se le rendirán.*

Nosotros no podeos determinar cuánto pagara su seguro por los servicios rendidos has después de que se remita la factura al seguro. La cantidad que su seguro pagara dependerá en el plan de seguro médico, y la cantidad que se aplicara al deducible, y/o el pago compartido son la responsabilidad del paciente. El copago por su consulta médica es requerido al llegar a su cita. En ocasiones el copago solo cubre el costo de la consulta y su seguro puede considera los servicios o procedimientos en adición a la consulta servicios quirúrgicos los cuales frecuentemente requieren deducibles y/o pago compartido.

Si no aceptamos su seguro médico, o no tiene cobertura de seguro, se requiere el pago inmediato por los servicios rendidos. Nosotros le podemos dar la documentación necesaria para que usted archive un reclamo con su seguro.

Yo he leído y entiendo el aviso con respeto a los reclamos / facturas / pagos de compañía de seguroy entiedo que es mi responsabilidad pagar por los servicios rendidos.

Patient/Guardian Signature
Firma del Paciente/Tutelar _____

Date
Fecha _____

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MEDICAL & HEALTH HISTORY

APPT DATE		ACCT NO.	

PATIENT INFORMATION
INFORMACIÓN DEL PACIENTE

LAST NAME *APELLIDO(S)*		FIRST NAME *PRIMER NOMBRE*		MIDDLE NAME *SEGUNDO NOMBRE*	
SEX *SEXO*		DATE OF BIRTH *FECHA DE NACIMIENTO*		HEIGHT *ESTATURA*	WEIGHT *PESO*
Reason for Today's Visit *Razón de la Visita de Hoy*					
Current or Most Recent Occupation *Ocupación Actual o Mas Reciente*					

PRIMARY CARE PROVIDER *MEDICO DE CABECERA*			PREFERRED PHARMACY *FARMACIA PREFERIDA*		
NAME *NOMBRE*			NAME NOMBRE		
CITY, STATE, ZIP CODE *CIUDAD, ESTADO, CÓDIGO*			CITY *CIUDAD*		STATE *ESTADO*

LIST OF MEDICATIONS CURRENTLY TAKING
LISTA DE MEDICAMENTOS QUE ESTA TOMANDO

Name of Medication *Nombre del Medicamento*	Dosage *Dosis*		Name of Medication *Nombre del Medicamento*	Dosage *Dosis*

ALLERGIES to MEDICATION
ALERGIAS a MEDICAMENTO

_____ INITIAL *INICIALES*

The above named patient does NOT have any known medication allergies.
El paciente, arriba identificado, NO tiene conocimientoto de alguna alergia a medicamentos.

_____ INITIAL *INICIALES*

The above name patient DOES have the following known medication allergies:
El paciente, arriba identificado, TIENE conocimientoto de las siguientes alergias a medicamentos:

Name of Medication *Nombre del Medicamento*	Type of Reaction *Tipo de Reacción*		Name of Medication *Nombre del Medicamento*	Type of Reaction *Tipo de Reacción*

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MEDICAL & HEALTH HISTORY CONTINUED

APPT DATE		ACCT NO.	

SURGERIES & HOSPITALIZATIONS
CIRUGÍAS & HOSPITALIZACIONES

PAST PROBLEMS ONS WITH ANESTHESIA
PROBLEMAS EN EL PASADO CON LA ANESTESIA

_____ **INITIAL** *INICIALES*	**The above named patient has NOT had any problems or complications with anesthesia (being numbed or put to sleep).** *El paciente, arriba identificado, NO ha tenido problemas o complicaciones al ser anestesiado.*
_____ **INITIAL** *INICIALES*	**The above name patient HAS HAD the following problems or complications with anesthesia (being numbed or put to sleep):** *El paciente, arriba identificado, HA TENIDO los siguientes problemas o complicaciones al ser anestesiado:*

LIST PAST SURGERIES WITH DATES
ENLISTE CIRUGÍAS INCLUYENDO LA FECHA

Surgery *Cirugía*	**Surgery Date** *Fecha de la Cirugía*		**Surgery** Cirugía	**Surgery Date** *Fecha de la Cirugía*

LIST PAST HOSPITALIZATIONS WITH DATES
ENLISTE HOSPITALIZACIONES INCLUYENDO LA FECHA

Hospitalization Reason *Razón de la Hospitalización*	**Hopitalization Date** *Fecha de la Hospitalización*		**Hospitalization Reason** *Razón de la Hospitalización*	**Hopitalization Date** *Fecha de la Hospitalización*

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AUTHORIZATION TO RELEASE INFORMATION

APPT DATE		**ACCT NO.**	
NAME		**DOB**	

I _____ hereby authorize Premier Orthopaedics & Sports Medicine, LLC to release any information regarding my condition and treatment to any referring or consulting healthcare personnel; any health, accident, auto, or worker's compensation insurance carrier, any agent, attorney, or other representative supporting to act on my behalf; and any facility at which I am treated, examined or evaluated. **I also authorize my insurance company or any other third party payer to *directly* pay Masoud Hamidian M.D. or Premier Orthopaedics & Sports Medicine, LLC any benefits due.** I understand that I am financially responsible for any amount not covered by my insurance. In the event that any unpaid balance reaches delinquent status, I agree to pay up to 35% of my balance in fees and costs that Premier Orthopaedics & Sports Medicine may accrue in collection of my balance owed, as well as an 18% per annum interest rate on the amount owed.

Also, hereby I give Premier Orthopaedics & Sports Medicine permission to discuss my (or the patient's) medical and financial information with the following individual(s):

Name of person(s) I permit to discuss my information:

1.) _____ _____
Person's Full Name — Relationship to Patient

2.) _____ _____
Person's Full Name — Relationship to Patient

3.) _____ _____
Person's Full Name — Relationship to Patient

4.) _____ _____
Person's Full Name — Relationship to Patient

_____ _____
Patient or Guardian Signature — **Relationship to patient**

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OFFICE POLICIES NOTICE & AGREEMENT

APPT DATE		**ACCT NO.**	
NAME		**DOB**	

- **Appointment Cancellations/No Shows:** This office sees a high volume of patients, to ensure that everyone receives the most prompt and courteous care available; please call us if you cannot keep your appointment time, so that it may be offered to another patient. In the event that a patient fails to show up for their appointment without notifying us, a **$25 charge** will be added to their account balance. Our staff makes every attempt to maintain the schedule and flow of patients. However, due to the nature of our business, circumstances may arise resulting in longer wait times than expected. Unfortunately, due to this, we cannot be held responsible for time lost during the wait. We apologize in advance for any inconvenience.
- **Payment for Services:** Payment is due at the time services are rendered. We will file claims to your insurance as a courtesy to you; however the balance accrued is ultimately your individual responsibility.
- **Work Statements:** Occasionally, it is necessary to provide a patient's employer with a statement regarding work. Physicians not only have ethical responsibilities with such matters but legal liabilities as well. In this event, a statement specific to the patient's condition is administered defining their **limitations**. It is the employer's responsibility to provide a position accommodating these limitations or determine if such a position is unavailable. Dr. Hamidian cannot write a statement removing a patient from work unless the patient is totally incapacitated, which is rarely indicated.
- **Pain Medication:** In the best interest of his patients, Dr. Hamidian strictly monitors the usage of narcotic pain medication in his practice. Pain medication is intended for **temporary** relief of symptoms. It is the primary goal of Dr. Hamidian to offer superior care to his patients. Therefore, his treatment is aimed toward the long term correction of an affecting condition. While situations do arise that necessitate pain medication, these types of drugs are very dangerous and can result in chemical dependency.
- **Paperwork Fees:** In compliance with the laws of the State of Alabama, our fees for medical records include a **$5.00** retrieval fee as well as the following:
  - Paper medical records: **$1.00** per page
  - Digital copies of X-Rays on CD-ROM: **$10.00**

  In addition, the completion of employment/insurance documents requires a charge of **$10.00 per page**. Our office is very busy meeting the needs of all patients; therefore it is not unusual for these requests to take 3-5 business days for completion.

Please sign below stating that you have read and do understand this agreement.

Patient or Guardian Signature	**Relationship to patient**

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NOTICE OF PRIVACY PRACTICES

APPT DATE		**ACCT NO.**	
NAME		**DOB**	

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to Premier Orthopaedics & Sports Medicine, the physician and other healthcare workers employed at this facility. It is our legal duty to protect the privacy of your information. We are providing this notice to you so that we can explain what our privacy practices are. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time. For more information about our privacy practices or to place a complaint or report a concern or conflict, call **Staci Ogle** at **(256) 574-2663.**

You may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate DHHS address. Under no circumstance will you be retaliated against for filing a complaint.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. For example, we may use your information in treatment situations if we need to send your medical record information to a specialist or physician as part of referral for continuity of care. We will send your health information and other identifying information to Medicare, Medicaid or other health insurance plans for our billing purposes. Your information will be used when processing your medical records for completeness and to compare patient data during our efforts to continually improve our treatment methods.

Under certain circumstances we may be required to disclose your health information without your specific authorization. Examples of these disclosures are: requirements by state and Federal laws to report cases of abuse, neglect, or other certain law enforcement purposes; for public health activities; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests, and to prevent serious threat to health or public safety. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health related services that may be of benefit to you. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Do remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request except to the extent that we may have already acted.

As a patient you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive a copy of your health information. There may be a preparation fee associated with making the copies. You can ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment payment and operations. We can provide you one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct the existing information. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can request that your health information be communicated to you at an alternate location or address. Finally, you can request in writing that we not use or disclose your information for any reasons described in this notice or to persons involved in your care except when specifically authorized by you or when required by law, or in emergency circumstances. We are not legally required to accept such a request but we will try to honor any reasonable requests.

Please sign and date below, stating that you have read and understand this notice.

Patient or Guardian Signature **Relationship to patient**

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