AZ Sports Medicine

Dr. Erik Dean **Dr. Victoria Eby**

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone #: _____ ☐ Cell ☐Home Work Phone #: _____

Email:_____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Marital Status: _____

Social Security #: _____ Employer/School: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Federal Privacy Standards require the following information:

Race: _____ Ethnicity:_____ Primary Language: _____
(i.e. Caucasian/Hispanic/Asian) (i.e. American/ Mexican/German)

How did you hear about us?

☐ Home ☐ Family Member ☐ Friend ☐ Internet ☐ School Athletic Trainer

☐ Another Physician (Name of Physician):_____ ☐ Other: _____

Responsible Party/Insured Party Information: (Please fill out completely, **if other than self**)

Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

E-mail: _____ Responsible/Insured Party's Employer: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Policy ID#: _____ Policy ID#: _____

Group #: _____ Group #: _____

Insurer's Address: _____ Insurer's Address: _____

If the primary policy holder is anyone other than you, please fill out Responsible Party/Insured Party Information above.

Signature: _____ Date: _____

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AZ SPORTS MEDICINE

Erik Dean, DO ♦ Victoria Eby, DO

Patient Name: _____DOB:_____Height:_____Weight:_____

What are you seeing the doctor for today: _____ Affected side: ☐ Left ☐ Right

Date of injury or onset of problem: _____ Dominant hand: ☐ Left ☐ Right

Work Related? ☐Yes ☐ No Auto Accident? ☐Yes ☐ No Attorney Involved? ☐Yes ☐ No

Have you had x-rays taken? ☐ Yes ☐ No If yes, where? _____

Have you had an MRI? ☐Yes ☐ No If yes, where? _____

Pharmacy: _____ Pharmacy Location (cross streets or address): _____

Pharmacy Phone Number: _____

Drug Allergies: ☐ Yes ☐ No Please list drug and reaction:_____

Daily Medications: (Please include pain meds, herbs, vitamins & OTC)

Name Dosage/Strength Times/day

_____

_____

_____

_____

Past Surgical History (List type and date):

_____

_____

_____

Past Medical/Hospital History (Illness/Conditions):

_____

_____

_____

Do you smoke? ☐ Yes ☐ No Packs per day:_____

For how many years?_____

Do you exercise? ☐ Yes ☐ No How Often?_____

What type? (Running, biking, etc.) _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, average consumption a week?_____

What is your occupation?_____

Do you now or have you ever had (please check):

Anemia……..	☐Yes ☐No
Diabetes……..	☐Yes ☐No
Cancer/Type……..	☐Yes ☐No
Kidney Trouble……..	☐Yes ☐No
Bladder Issues……..	☐Yes ☐No
High Blood Pressure……..	☐Yes ☐No
Heart Trouble……..	☐Yes ☐No
High Cholesterol……..	☐Yes ☐No
Asthma……..	☐Yes ☐No
Neurological Disorder/Seizures……..	☐Yes ☐No
Depression……..	☐Yes ☐No
Stroke……..	☐Yes ☐No
Thyroid Disorder……..	☐Yes ☐No
Ulcer/Stomach Problems……..	☐Yes ☐No
Hepatitis (Type)……..	☐Yes ☐No
Arthritis……..	☐Yes ☐No
Gout……..	☐Yes ☐No
Phlebitis/Blood Clots……..	☐Yes ☐No
AIDS/HIV……..	☐Yes ☐No
Substance Abuse……..	☐Yes ☐No
Fibromyalgia……..	☐Yes ☐No
Sleep Apnea……..	☐Yes ☐No

Family History:
Please list any major medical conditions and indicate if they are deceased or alive:

Father:

Mother:

Siblings:

Is there any possibility you could be pregnant? ☐ Yes ☐ No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? ☐ Yes ☐ No

If yes, who and what is their age:_____

Have you or any blood relative, younger than 50, ever had a serious reaction to anesthesia? ☐ Yes ☐ No

If yes, who and what is their age?_____

The above information is, to the best of my knowledge, a true statement of my current condition.

Patient Signature:_____Date:_____

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AZ Sports Medicine
Dr. Erik Dean, Dr. Victoria Eby
Consent Form

Patient Name: _____ **Birth Date:** _____

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that AZ Sports Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact AZ Sports Medicine at any time to obtain a current copy.

**Signature:_____Date:_____

I may be contacted in the following manner (check all that apply):

Ok to leave message with detailed information: ☐ Home ☐ Work ☐ Cell ☐ No

Ok to leave call back number only: ☐ Home ☐ Work ☐ Cell ☐ No

Ok to email to: _____

Authorization of Release of Health Information:

I authorize the following individual(s) to have access to my personal health information.

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

** Signature:_____Date: _____

Workman's Compensation (if applicable):

Insurance Carrier: _____ Claim #:_____ Date of Injury: _____

Address: _____ City:_____ State:_____ Zip:_____

Adjuster: _____ Phone: _____ Fax:_____

Nurse Case Manager: _____ Phone:_____ Fax:_____

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Patient Payment Policy

1. Co-Payments, Co-Insurance and Deductibles: ***All co-payments, co-insurance and deductibles must be paid in full at the time of service.*** The amount collected at the time of service is ***only an estimate*** and the final amount due will be determined by your insurance company when the claim has been processed. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from our patients can be considered fraud. Please help us in upholding the law and paying your co-payment and/or deductible and co-insurance at each visit.

(Initial here) _____

2. Proof of Insurance: All patients must complete all patient forms before seeing the doctor. We must obtain a copy of your valid driver's license and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of your claim.

(Initial Here) _____

3. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company since we are not party to that contract.

(Initial Here) _____

4. Coverage Changes: If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

(Initial Here) _____

5. Non-payment: If your account is over 30 days past due after your insurance has paid their portion and a statement has been sent out and you have failed to pay the remaining balance you owe, an 18% finance charge will be charged to your account as of the 30 days from the date the statement was mailed to you. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency at any time after 30 days of nonpayment. In addition you and your immediate family members may be discharged from our practice. In the event of finding it necessary to turn your unpaid balance over to a collections agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30- day period, our physicians will only be able to treat you on an emergency basis.

(Initial Here) _____

6. In case of Divorce/Custody Issues: We cannot become involved with double billing in divorce settlements. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service.

(Initial Here) _____

7. No-Show & Cancellation Policy: Failure to show up to your appointment within 15 minutes of your scheduled appointment time or failure to cancel your appointment at least one business day in advance will result in a $50 fee for New Patients or a $25 fee for Established Patients automatically charged to your account.

(Initial Here) _____

New Policy: You will be asked for a credit card at the time of booking your Initial Evaluation. The information will be held securely until your insurances(s) have paid their portion. You will be responsible for payment of all services performed (this will be an estimate based on information provided by your insurance company.) If you do not check out and pay for these services we will charge your card on the date of service. If a patient balance remains, a statement will then be sent to you. Any balance remaining after 30 days will be charged to your card unless other payment arrangements have been made.

Failure to show up to your appointment within 15 minutes of your scheduled appointment time or failure to cancel your appointment at least one business day in advance will result in a fee ($50 for New Patients & $25 for Established Patients) automatically charged to your account. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Credit Card Information:
Type of Card (Please Check): ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Card# _____ Expiration Date _____/_____ Security Code: _____

Billing Address: _____ City_____ State _____ Zip _____

Phone # _____

***Finance Charge: All Patients have a responsibility to keep their accounts current. A finance charge of 18% per month will be charged to all accounts 30 days delinquent.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
I have read and understand the payment policy of Dr. Erik Dean, and Dr. Victoria Eby and agree to abide by its guidelines:

_____
Patient's Name

_____ _____
Signature and Name of Responsible Party Date

Card Holder Name (if different) _____

Card Holder Signature _____ Date: _____

Clear **Print**