SUNNYVALE SPORTS MEDICINE AND ORTHOPEDIC CENTER

Today's Date: _____

Patient Name:_____Date of birth:_____
Age: _____ Social Security Number: _____

Gender: M F

Preferred Phone: _____

Secondary Phone: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____
Employer:_____ __

Job Title: _____ _

Financial Responsible Party (if different than patient or if patient is a minor):

_____

Social Security Number: _____ Date of birth: _____
Relationship: _____ Emergency Contact:_____
Relationship: _____ _____Phone: _____

Primary Care Physician: _____

Referring Physician: _____ Pharmacy_____

Ethnicity (Please Circle One): Race (Please Circle One): ♦ Hispanic or Latino ♦ Not Hispanic or Latino ♦ Decline ♦ American Indian or Alaska Native ♦ Asian ♦ Black or African American ♦ Native Hawaiian or Pacific Islander ♦ White ♦ Decline Date of Injury (if applicable):

_____

** **Will this injury be filed with Worker's Compensation? o Yes o No**

Worker's Compensation Information (If Applicable, please fill out completely) Claim Number: _____

Employer Name: _____

Employer Address: _____

City: _____

State: _____ Zip: _____ Employer Phone: _____

Adjustor Name: _____ Adjuster Phone: _____

Personal Insurance

Primary Insurance Carrier: _____

Member ID: _____ _____

Group Number: _____ _____

Policy Holder's Name: _____ _____

Policy Holder's Date of Birth: _____ _____

Policy Holder's Social Security Number: _____ _____

Relationship to Policy Holder: _____ _____

Secondary Insurance Carrier: _____

Member ID: _____ _____

Group Number:

_____

Policy Holder's Name:

_____

Policy Holder's Date of Birth:_____ _____

Policy Holder's Social Security Number: _____Relationship to Policy Holder:_____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient or Guardian Signature: _____
Date:_____

SUNNYVALE SPORTS MEDICINE
AND ORTHOPEDIC CENTER

Patient Medication Policy

Our patients are very important to us. Our goal at Sunnyvale Sports Medicine & Orthopedic Center is to provide you with the best treatment possible in a pleasant and caring manner. We are sensitive to the pain you may be experiencing. For this reason your doctor may prescribe medication to help you with the pain.

General Medication Policy for patients:

1. All medications should be taken as instructed by your physician.

2. Please contact your pharmacy for medication refills. They will contact us. This reduces the possibility of errors being made when filling your prescription.

3. If all medication is taken prior to the approximated refill time, the request will be denied.

4. Medication refills will only be accepted Monday through Thursday during normal business hours.

5. Medication refills sent to the office after 3:00 PM will not be addressed until the next business day.

6. Medications will not be filled on holidays or weekends by the on-call doctor. Please plan accordingly and contact your pharmacy, prior to running out of your prescription.

7. It is our policy not to prescribe medications for undiagnosed pain.

8. Schedule II narcotic medications cannot be called into the pharmacy. Those must be written or may be processed electronically as mandated by federal law.

9. If medication is needed beyond the normal post-operative period, or if pain persists after completion of non-surgical treatment, you will be referred to a pain management program. At this point all pain medication will be prescribed by the pain specialists and not by our office. The pain specialist will inform our office of your progress.

10. Surgery Patients – we will NOT refill pain medication: a. 4 – 6 weeks after a knee, hip, or shoulder arthroscopic procedure, carpal tunnel release, ankle ligament repair/reconstruction, fracture fixation or total joint replacement. b. 8 – 10 weeks after a reconstruction of shoulder ligaments or rotator cuff / Bankart repair, or total shoulder replacement. Exceptions to the above guidelines will be at the discretion of the treating physician. Patient's please understand there are non-narcotic pain management options that will minimize your post-operative pain and we are happy to assist with these options if needed.**

Patient Signature:_____Date:_____

Patient Name_____

Date of Birth_____

Sunnyvale Sports Medicine and Orthopedic Center

GENERAL INFORMED CONSENT

1. I hereby authorize **John Hibbitts, MD** and/or such assistants and associates as may be selected by him to perform the following procedure(s)/treatment(s) upon the patient.

   Procedure(s)/Treatment(s) : Orthopedic Evaluation & Treatment

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/ or clinical observations performed. I have been informed of the following:
   - A description of the proposed procedure/treatment
   - The indications for the proposed procedure/treatment
   - Material risks and benefits for the patient related to the treatment based on the available clinical information and dependent upon the professional custom and standard.
   - The likelihood of the patient achieving his or her goals.
   - Treatment alternatives, including the attendant material risks and benefits
   - The probable consequences of declining the recommended or alternative therapies
   - Who will provide the procedure/treatment
   - When indicated, any limitations on the confidentiality of information learned from or about the patient

   I understand the information provided and give this consent voluntarily.

3. I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and drugs: (If none, please write no drug or substance allergies)
   _____

4. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/ treatment(s).

5. For the purpose of advancing medical education, I consent to the admittance of observers to the room in which the procedure(s)/treatment(s) is performed. Such observers may be health care professionals, students, clinical device specialists or others as may be identified by my physician /health care provider.

6. I acknowledge that I have read and fully understand this document and that if I have any questions I have had the opportunity to have them answered by the physician/health care provider.

Date: _____ _____

Signature of Consenting Party

Time: _____ A.M. / P.M. _____

Print Name

INFORMED CONSENT AFFIRMATION

My signature below affirms that prior to the time of the procedure, I provided to the patient and/or his/her guardian the information contained in paragraph 2 above verbally, by means of an information sheet and/or other audio/visual means of communication.

Sunnyvale Sports Medicine and Orthopedic Center, PLLC

PF-1000

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment - You health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will share some of all of your medical information with that physician to facilitate the delivery of care. We may also share some of your information with other primary care physicians that share call with our practice. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. We may also provide pharmacies with your information to respond to the filling of prescription requests and related issues.

Individuals that we may Release/Disclose Health & Financial Information To:

_____

_____

Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations – Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement – Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting – Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

_____ _____

Patient Name Print Date

_____

Patient Signature

Sunnyvale Sports Medicine & Orthopedic Center
Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, Sunnyvale Sports medicine & Orthopedic Center have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept [VISA, MasterCard, Discover, and American Express & Care Credit].

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

SUNNYVALE SPORTS MEDICINE
AND ORTHOPEDIC CENTER

NO SHOW POLICY

THERE WILL BE A **$75.00 NO SHOW FEE** ADDED TO YOUR ACCOUNT FOR ALL NO SHOW APPOINTMENTS AND CANCELLATIONS WITH **LESS THAN 24 HOUR NOTICE**.

FMLA PAPERWORK

This office does complete FMLA paperwork. There will be a **$50.00 FEE** for any leave of absence paperwork that needs to be completed.

TEMPORARY HANDICAP PLACARD

This office can provide patients with Temporary Handicap Placard paperwork to take to the DMV. There is a **$25.00 FEE** for the paperwork.

BY SIGNING BELOW, YOU UNDERSTAND AND AGREE WITH OUR TERMS.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

SUNNYVALE SPORTS MEDICINE
AND ORTHOPEDIC CENTER

Orthopedic Surgery & Sports Medicine
Patient History Questionnaire

Name: _____ **DOB:** _____ **Age:** _____ M ☐ F ☐

Referring Physician: _____ **Family Physician:** _____

HISTORY OF YOUR PROBLEM:

Date of Injury (if applicable):_____

What problem can we help you with today?

Please describe your symptoms and any prior tests, x-rays, treatments or prior surgeries:

Intensity of Pain, Scale 0 to 10 (0=No pain, 10= Worst Pain imaginable): _____

YOUR MEDICAL HISTORY:

*Please check or list **ALL** medical problems or conditions that you have been or currently are being treated for.*

☐ Hypertension/High blood pressure	☐ Diabetes	List any other conditions here:
☐ Heart disease/coronary artery disease	☐ Rheumatoid arthritis	
☐ Irregular Heart rhythm	☐ Gout	
☐ High cholesterol	☐ Sleep apnea	
☐ Peripheral vascular disease	☐ Osteoporosis	
☐ Reflux disease/Heartburn	☐ Thyroid disease	
☐ Stomach Ulcers	☐ Stroke	
☐ Asthma	☐ Cancer	
☐ COPD/Emphysema	☐ Kidney disease	
☐ Blood clots/abnormal clotting	☐ HIV/AIDS	
☐ Abnormal bleeding	☐ Hepatitis A☐ B☐ C☐	

MEDICATIONS:

*Please list **ALL** medications you take regularly (include non-prescription meds).*

☐ **See attached list**

Name & Dose (mg)	How often?	Name & Dose (mg)	How often?
1.		7.	
2		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

ALLERGIES: NONE ☐ YES ☐→ *If yes, please list the medication and your reaction to it below.*

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

SURGICAL HISTORY: (Please list *ALL* surgeries you have had in the past)

Year	Type of Surgery	Year	Type of Surgery
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Did you have any complications after surgery? (i.e., blood clot, nausea, problems with anesthesia)

No ☐ **Yes** ☐ **If yes, please explain:**

FAMILY HISTORY:

Mark any conditions that your parents or siblings have/had by indicating the family member (**M**=Mother, **F**=Father, **B**=Brother, **S**=Sister) after the condition:

High Blood Pressure:	Diabetes:	Other:
Heart Attack:	Thyroid Disease:	
Coronary Artery Disease:	Blood Clots:	
Heart Valve Disease:	Seizures:	
Irregular Heart Rhythm:	Cancer:	
Peripheral Vascular Disease:	Stroke:	
Hepatitis: A☐ B☐ C☐	Kidney Disease:	
Asthma:	Tuberculosis:	
Lung Disease:	Immunodeficiency:	
Arthritis:	Osteoporosis:	

SOCIAL HISTORY:

Marital Status:	**Married** ☐ **Single** ☐ **Widow(er)** ☐ **Divorced** ☐
Are you currently working?	**Yes** ☐ **No** ☐ **Retired** ☐ **Occupation:** ____________________
Do you drink alcohol?	**Yes** ☐ **No** ☐ How much? (circle) *rarely occasionally daily weekly*
Do you smoke?	**Yes** ☐ **No** ☐ How much? _____ packs per day for _____ years
	Quit ☐ (Year you quit:_______) _____ packs per day for _____ years
History of substance abuse?	**Yes** ☐ **No** ☐ If yes, what substance:

REVIEW OF SYSTEMS: *(Do you **currently** have any of these symptoms? If yes, please circle)*

System		Symptoms/Problems				Other:
General	NONE	Fever	Chills	Weight loss	Weight gain	
Eyes/Vision	NONE	Blurriness	Dry eyes	Double vision	Headaches	
Ears/Nose/Throat	NONE	Vertigo	Sinusitis	Hoarseness	Hearing loss	
Heart	NONE	Chest pain	Murmurs	Palpitations	Irregular rhythm	
Lungs	NONE	Shortness of breath	Asthma	Cough	Wheezing	
Circulation	NONE	Blood clot	Swelling	Cramping	Varicosities	
Digestive Tract	NONE	Diarrhea	Constipation	Ulcers	Reflux	
Kidney/Urinary	NONE	Stones	Burning	Bleeding	Itching	
Skin/Breast	NONE	Rash	Lump	Itching	Hair/nail changes	
Endocrine	NONE	Decreased energy	Excess thirst	Excess sweating		
Neurologic	NONE	Numbness	Tingling	Tremors	Loss of balance	
Psychiatric	NONE	Depression	Anxiety	Sleep disorder		
Blood/Lymph	NONE	Bleeding problems	Easy bruising	Prior transfusion	Anemia	
Musculoskeletal	NONE	Arthritis	Joint swelling	Cramps	Muscle spasm	

Patient Signature: ______________________________ **Date:** ______________

- -

Vital Signs **Height:** __________ **Weight:**__________ **BMI:** _________

BP: __________ **HR:** __________ **RR:** __________ **Temp:** ________

PA/RN/MA Signature: ________________________ **Date/Time:** ________________

MD Signature: ______________________________ **Date/Time:** ________________