Mississippi Sports Medicine

And Orthopaedic Center

Thank you for choosing Mississippi Sports Medicine And Orthopaedic Center for your care and treatment. Please complete the enclosed forms and bring them with you when you arrive for your appointment.

KINDLY BRING COMPLETED FORMS WITH YOU. DO NOT MAIL. THANK YOU!

If you need to cancel or reschedule your appointment, please call us at (601) 354-4488 at least 24 hours in advance. There is a $30 fee if you do not cancel or reschedule your appointment with proper notice.

Please arrive 15 minutes prior to your appointment, if you have finished all paper work. If you DO NOT have your paperwork completed, please arrive 30 minutes prior to your appointment.

Please bring your picture I.D. and insurance cards along with these completed forms. Any applicable co-pays or coinsurance will be collected at the time of service.

Please bring a list of all medications that you are currently taking, X-rays, MRI films, or any other medical records that may be pertinent to this visit.

If this visit is due to an accident that is covered by workers' compensation, please have your employer or adjuster furnish the name, injury date, workers' compensation carrier name, claim number, billing address and phone number. These are required for your visit.

Important Insurance Information

Our staff is here to help ensure your claims are paid in a timely manner. Please take a minute to read the information below to assist us to get your claims paid.

- If your visit is due to an injury, your insurance company may require additional information from the patient. Your insurance company will mail the patient or the guarantor a form to fill out. If this form is NOT filled out, the claim is usually denied pending this information and will be the patient's responsibility. You should receive this request within 30 days of your visit.
- If you do not receive an injury form or an explanation of benefits (details on what has been paid or denied by your insurance company) please contact your insurance company.
- If your injury is due to an auto accident, we will need a letter from your auto insurance stating you have exhausted your medical pay. We will need this letter to file your claim to your health insurance.
- Please let our front desk personnel know if your insurance has changed since your last visit with us. Keeping us informed of any changes will help us in filing your claim correctly and in a timely manner. Please always use your complete legal name. If your name on the insurance card and the name you give us DO NOT match, we will not be able to file your claim.

_____

Patient Initials

Notice Of Privacy Practices For Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please read it carefully.

Mississippi Sports Medicine and Orthopaedic Center is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. Mississippi Sports Medicine and Orthopaedic Center is required by law to abide by the terms of this notice, and we reserve the right to change the terms of notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this notice, we will post a revised notice at the hospital and/or clinic and will make paper copies of this notice or Privacy Practices for Protected Health Information available upon request.

How Your Medical Information Will Be Used And Disclosed:

We will securely store your medical information on a computer for use as part of rendering patient care. For example, your medical information may be used by the health care professional treating you, by the business office to process your payment for the services rendered and by the administrative personnel reviewing the quality and appropriateness of the care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination or the Hospital's compliance with relevant laws.
- Unless you object, we will include general information, including your name, location in the clinic, your condition described in general terms and your religious affiliation in a directory of individuals located in the clinic. The directory information, except for your religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
- Unless you object, we may disclose to family members, other relatives or close personal friend the medical information directly relevant to such person's involvement with your care.
- Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.
- We may disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.

_____

Patient Initials

- We may use or disclose your information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- We may disclose your medical information in the course or certain judicial or administrative proceedings. We may disclose your medical information for law enforcement purposes or other specialized government functions.
- We may disclose your medical information to a coroner, medical examiner or a funeral director.
- If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.
- We may disclose your medical information for certain research purposes.
- We may use or disclose your medical information to prevent or lessen a serious threat to health or safety or another person or the public.
- We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

Your Rights Regarding Your Medical Information:

You have the following rights with respect to your medical information.

- The right to request restrictions on certain uses and disclosures of your medical information. We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with a written explanation for the denial and information regarding further rights you would have at that point.
- The right to receive an accounting of the disclosures of your medical information made by the clinic in the six years prior to your request, except for disclosures for treatment, payment or clinic operational purposes, and for other certain specifications disclosure types.

_____

Patient Initials

- The right to request a paper copy of this notice of Privacy Practices for Protected Health Information.
- The right to complain to the clinic and/or to the United States Department of Health and Human Services if you believe that Mississippi Sports Medicine has violated your privacy rights. If you choose to file a complaint you will not retaliated against in any way.

If you would like further information regarding your rights or the uses and disclosures of your medical information you may contact our administrator.

Mississippi Sports Medicine And Orthopaedic Center, PLLC
ATTN: Glen Silverman, CEO
1325 East Fortification Street Jackson MS 39202
Phone: 601-354-4488
Fax: 601-914-1849

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Patient Signature: _____

Mississippi Sports Medicine & Orthopaedic Center, PLLC
& the Therapy Center for Mississippi Sports Medicine

Patient Demographic & Insurance Information

Today's Date: _____

Patient Legal Name: _____ Account #: _____
First Name Last Name

Mailing Address: _____
Address City State Zip

Same as above ❑
Billing Address: _____
Address City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Patient SSN: _____ - _____ - _____ Gender: ❑ Male ❑ Female Age: _____ DOB: _____ /_____ /_____

Responsible Party Demographic Information

Same as above ❑

Patient's Relationship to Responsible Party: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other: _____

Name of Responsible Party: _____ Gender: ❑ Male ❑ Female

Mailing Address: _____
P.O. Box City State Zip

Same as above ❑
Billing Address: _____
P.O. Box City State Zip

SSN: _____-_____-_____ DOB: _____ /_____ /_____

Policy Holder Primary Insurance

Insurance Name: _____

Employer : _____

Group Name / #: _____

Policy Number: _____ SSN: _____-_____-_____

Relationship to the Patient: _____

DOB: _____ /_____ /_____ Eff. Date: ___ / ___ / ___
MM D YY

Policy Holder Secondary Insurance

Insurance Name: _____

Employer : _____

Group Name / #: _____

Policy Number: _____ SSN: _____-_____-_____

Relationship to the Patient: _____

DOB: _____ /_____ /_____ Eff. Date: ___ / ___ / ___
MM D YY

I hereby authorize payment directly to Mississippi Sports Medicine and Orthopaedic Center, PLLC, for medical services rendered. I authorize the release of my medical information deemed necessary in the processing of a claim. It is my understanding that I am responsible for this amount, regardless of insurance coverage.

I have received a copy of Mississippi Sports Medicine and Orthopaedic Center's Privacy Policy.

Date: _____/_____/_____ Signature: _____

Additional Patient Information

Student: ❑ Yes ❑ No If yes, name of school: _____

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ American Indian ❑ Hispanic ❑ Other: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Patient Employer: _____ Spouse Employed: ❑ Yes ❑ No Employer: _____

Who referred you to us? _____ State: _____

Who is your family physician? _____ City: _____ Phone: _____

Emergency Contact Information/HIPAA Release

Name: _____ City: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Relationship to Patient: _____

Would you like to permit the above individual or any other individual to receive information regarding medical and/or billing questions? ❑ Yes ❑ No

Additional Individual Name: _____

Relationship to Patient: _____

Patient Signature:_____

Physician Disclosure of Financial Interest

Notice to patients treated by Mississippi Sports Medicine and Orthopaedic Center, PLLC:

Both Federal and Mississippi law requires that your physician disclose to you any financial interest he or she may have in an entity to which you may be referred, so that you may address any concerns you may have directly with your physician.

Your referring physician is an owner of Mississippi Sports Medicine. This notice is to let you know that Mississippi Sports Medicine owns its own MRI Services, CT Services, and the Flowood Surgery Center. The physician owners may refer you for additional services needed to diagnosis, therapeutically treat, or surgically repair your medical condition to one of these entities listed above.

By signing the below, you acknowledge your receipt of this Physician Disclosure of Financial Interest and understand that your referring doctor is an owner of this facility. A list of alternative facilities can be provided to you upon request.

Patient Signature:_____

❑ I agree to receive future email correspondence to this email address: _____

❑ I agree to receive future SMS/Text messages to this number (messaging charges may apply if your cell phone rate plan does not include SMS/text messages: _____-_____-_____)

Date: ____/____/____ Print Name: _____ Signature: _____

Please sign and date only if you opt-in to receive text or email correspondence

Date: _____

Patient Account #: _____

NEW PATIENT MEDICAL HISTORY FORM

Mississippi Sports Medicine And Orthopaedic Center

Patient Name: _____ D.O.B.: _____ Height: _____ Weight: _____

Race: ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○ Other ○ Unknown ○ Decline to Answer

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Family Physician: _____

Preferred Pharmacy: _____ or ○ Mississippi Sports Medicine Pharmacy

SAVE TIME! Have your prescriptions filled or shipped before you leave the building!

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Social History

Do you use tobacco products or use illegal drugs?

○ Current, everyday use ○ Current, sometimes use ○ Former user ○ Never
○ Heavy tobacco use ○ Light tobacco use ○ Illegal drug use

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Pneumonia & Flu Vaccine: ○ Yes ○ No

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ ○ Student

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○
Thumb	○ Right	○ Left	Foot	○ Right	○ Left		
Index	○ Right	○ Left	Great Toe	○ Right	○ Left		
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left		
Ring	○ Right	○ Left	3rd Digit	○ Right	○ Left		
Little	○ Right	○ Left	4th Digit	○ Right	○ Left		
			5th Digit	○ Right	○ Left		

Pain radiates from/to: (ex. from low back to right leg) _____

 Patient Name: _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

If an injury, please provide date of injury and describe how you were injured:

_____/_____/_____ _____

_____

_____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

4. Have you been seen in an ER for this problem? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Other/Comments: _____

_____

_____

Select all previous hospitalizations/surgeries: ○ None

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
TotalShoulderReplacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

 Patient Name: _____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None for all

				None	Comments
1) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	_____
2) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	_____
3) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
4) CV	○ Chest Pain	○ Palpitations		○	_____
5) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	_____
6) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
7) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
8) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
9) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
10) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
11) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	_____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

 Patient Name: _____ Account #: _____

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____ Last A1C: _____		○ Stroke / TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date