TOTAL SPORTS MEDICINE & ORTHOPEDICS

10105 Banburry Cross Dr #445, Las Vegas, NV 89144
Phone: (702) 475-4390 Fax: (702) 951-5456
www.totalsportsmedicine.com

PATIENT INFORMATION

Patient Name: _____ ☑Dr ☐Mr ☐Mrs ☐Ms

Date of Birth: ____/____/____ SSN: ____-____-____(required for billing)

Address:_____

City: _____ State:_____ Zip:_____

Phone: _____ Email:_____

Preferred contact: ☐Call ☐Email ☐Text

Do you have an Advanced Directive/Living Will? ☐No ☐Yes: _____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ ☐Dr ☐Mr ☐Mrs ☐Ms

Date of Birth: ____/____/____ SSN: ____-____-____(required for billing)

Address:_____

City: _____ State:_____ Zip:_____

Phone: _____ Email:_____

Preferred contact: ☐Call ☐Email ☐Text

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship to patient:_____

PRIMARY INSURANCE INFORMATION (must be completed even if cards provided)

Primary Insurance: _____Subscriber Date of Birth:____/____/____

Primary Insurance Subscriber: _____ Member ID:_____

Group: _____ Relationship to patient: _____

SECONDARY INSURANCE INFORMATION (must be completed even if cards provided)

Primary Insurance: _____Subscriber Date of Birth:____/____/____

Primary Insurance Subscriber: _____ Member ID: _____

Group: _____ Relationship to patient: _____

TOTAL SPORTS MEDICINE & ORTHOPEDICS

Patient Name: _____ Date of Birth: _____/_____/_____

FINANCIAL POLICY

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your Health Insurance Company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. The patient's "responsible portion" is due at the time of service. This includes copayments. We will do all we can to assist you with your health insurance claims, however insurance is a contract between the insured and the insurance company. Final responsibility for payment of your account rests with you. If you are scheduled for surgery, we may require a deposit, which must be paid prior to your date of surgery. Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist. In the event that your account becomes delinquent, it will be forwarded to a collection agency. By signing below, I agree to pay all incurred charges, legal fees and court costs. A returned check charge of $25 will be charged to my account for each returned check. If a returned check is not made whole (paying the original check amount plus the fees) the returned check will be sent to the Clark County District Attorney's office for additional processing. Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medigap, Veterans' Administration or other designated payer of medical benefits to Orthopedic Solutions LLC for services furnished to me. The assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of this assignment is considered as valid as the original. There will be a $75 fee for all Family Medical Leave Act (FMLA) or Disability forms that must be filled out by providers at Total Sports Medicine and Orthopedics. Fee covers 6 months of revision to paperwork.

Acknowledgement and Receipt of Privacy Practices

Total Sports Medicine is required by US Federal Law to maintain our patients' privacy and provide them with access to the notice of our legal duties and privacy practices with respect to protected health information (PHI). Your signature below hereby acknowledges that you have reviewed our HIPAA Notice of Privacy Practices document and understand that you may obtain a copy for your records upon request. I hereby sign to Orthopaedic Solutions LLC all benefits for medical and surgical care payable under the policies of the practice. I also authorize the release of information under the same policy. I understand that I am financially responsible for any changes not covered by my insurance.

Prescription Drug Policy

New policies by the Drug Enforcement Agency (DEA) have forced us to create our own stricter rules regarding prescription drugs, beginning in our office November 1, 2015. Narcotic pain pills can no longer be called into the pharmacy. Narcotic pain pills are ONLY prescribed in our office for fractures (broken bones), after a surgery, or for other serious, acute injuries. We do not treat chronic pain. If you have been given a narcotic pain prescription, this will NOT continue to be filled after 8 weeks after your injury or surgery. If you are still having pain issues that are far out from injury or surgery, we will refer you to a pain management specialist, who can appropriately manage your pain and assist you in your transition away from these medications. You cannot obtain prescriptions from more than one doctor. This information is tracked by the DEA and a second prescription will not be filled by the pharmacy. ALL prescription drugs require documentation from an office visit and examination or the prescription is ILLEGAL. This means that if you feel you need a prescription of any kind, you will need an appointment to see the physician. This includes prescriptions that have been given to you in the past. If you are in need of a prescription and the physician is not in the office, you will need to see your primary care doctor, another doctor, or go to the Emergency Room or Urgent Care. Plan ahead if you recognize you may be running low on a prescription you are currently using. By signing below, I acknowledge and agree to this policy.

_____	_____	_____
Print Name (Patient)	Signature	Date
_____	_____	_____
Print Name (Guardian, if minor)	Signature	Date

SSN of Patient (Parent/Guardian, if minor): _____

TOTAL SPORTS MEDICINE & ORTHOPEDICS

For Office Use Only:
Ins:
DOB:
Chart #:
Time In:

Patient Name: _____

Age: _____ Height: _____ Weight: _____

Who referred you? ☐ Yelp ☐ Google ☐ Friend/Family/other: _____

Are you currently employed? ☐ No ☐ Yes, occupation? _____

Have you had any of these: ☐ x-ray ☐ MRI ☐ CT where: _____

Sport history (if applicable): ☐ HS ☐ College Sport: _____

What body part bothers you? _____

What side? ☐ right ☐ left When did it start? _____

Describe the problem: ☐ constant ☐ intermittent ☐ dull ☐ sharp ☐ burn

_____

_____

Check all that apply: ☐ instability ☐ stiffness ☐ weakness ☐ numbness ☐ pain radiates where: _____

Worse with: ☐ sitting ☐ standing ☐ walking ☐ bending ☐ stairs ☐ lifting ☐ overhead activities ☐ reaching

☐ pain wakes you up at night

☐ use crutches/walker/wheelchair

Were you injured in a motor vehicle accident? ☐ No ☐ Yes

Was there an injury? ☐ No ☐ Yes

Was it on the job? ☐ No ☐ Yes

Have you had any of the following treatments for this issue: ☐ injection ☐ surgery ☐ physical therapy

☐ evaluated by Orthopedic Surgeon: _____

☐ medications for pain: _____

For Office Use:

TOTAL SPORTS MEDICINE & ORTHOPEDICS

Patient Name:_____

Primary Care Doctor Name: _____ Primary Care Phone:_____

Pharmacy Name: _____ Address: _____

ALLERGIES

Medication: _____Reactions: _____Medication: _____Reactions: _____

Medication: _____Reactions: _____Medication: _____Reactions: _____

Non-Medication Allergies: ☐Metals ☐Iodine ☐Injections ☐Latex ☐IV Dye ☐Other:_____

MEDICATIONS (Please list all medications you are taking)

Medication: _____Medication: _____Medication: _____Medication: _____

Medication: _____Medication: _____Medication: _____Medication: _____

Medication: _____Medication: _____Medication: _____Medication: _____

Medication: _____Medication: _____Medication: _____Medication: _____

MEDICAL HISTORY (Please check all that apply):

Constitutional: ☐Fever/Chills ☐Weight gain/loss ☐Fatigue ☐Excessive/Lack of sleep

Heart: ☐High Blood Pressure ☐High Cholesterol ☐Coronary Artery Disease ☐Heart Attack ☐Congestive Heart Failure ☐ Arrhythmias ☐Chest pain ☐Irregular heartbeat ☐Leg swelling

Lung: ☐Asthma ☐COPD ☐Sleep Apnea ☐Shortness of breath ☐Wheezing

Gastrointestinal: ☐GERD ☐Peptic Ulcer

Hematology: ☐Blood Clots ☐Bleeding Disorder ☐Cancer ☐Easy bruising/bleeding ☐Anemia ☐Prior transfusion: ____

Infectious: ☐Seasonal allergies ☐Hay fever symptoms ☐HIV ☐Hepatitis: ☐A ☐B ☐C ☐D

Endocrine: ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Heat/cold intolerance ☐Diabetes ☐Type I ☐Type II

ENT: ☐Difficulty with hearing ☐Ear pain ☐Runny nose ☐Mouth sores ☐Sore throat

Ophthalmology: ☐Vision changes ☐Blurred vision ☐Double vision

Neurological: ☐Dizziness ☐Memory loss ☐Headache ☐Seizures ☐Problems with balance

Nephrology: ☐Urinary incontinence ☐Urinary retention ☐Urinary frequency ☐Burning ☐Kidney Failure

Psychiatric Problems: ☐Anxiety ☐Depression ☐Hallucination

Integumentary: ☐Rash ☐Hair loss ☐Skin lesion ☐Dry skin

SURGICAL HISTORY (Please list surgery and date of surgery)

Procedure: _____ Date: _____Procedure: _____ Date: _____

Procedure: _____ Date: _____Procedure: _____ Date: _____

Any complications from surgery? ☐No ☐Yes:_____ Any complications from anesthesia? ☐No ☐Yes:_____

SOCIAL HISTORY

Ethnicity:_____ Languages:_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Do you smoke? If yes, how long?_____ Do you use recreational drugs? ☐No ☐Yes, specify : _____

Do you drink alcohol? If yes, how long?_____

FAMILY HISTORY:

Mother: ☐Living ☐Deceased Any Medical Issues?:_____

Father: ☐Living ☐Deceased Any Medical Issues?:_____

Other:_____

TOTAL SPORTS MEDICINE & ORTHOPEDICS

HIPAA NOTICE OF PRIVACY PRACTICES

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

I, _____, give permission to Total Sports Medicine and Orthopedics to:

____ Obtain the following protected health information FROM:_____

____ Disclose the following protected health information TO: _____

Name of Provider: _____

Address:_____

Phone:_____ Fax:_____

"Health records" are records describing my health history, symptoms, examinations, test results and diagnoses. Treatment and any plans for future care or treatment. I understand this information is to be used serves as:

A basis for planning my care and treatment.
A means of communication among the many health professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party payer can verify that services billed were actually provided.

I request the following person to be able to obtain access to my healthcare information and to discuss my care with the doctor and staff.

Name:_____ Relationship:_____

This authorization expires 2 years (two years) from the date of signature. I understand I have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosure. The Notice Of Privacy Practices describes specific uses of your Protected Health Information.

A photocopy of this authorization is to have the same force and effect as the original. I understand that I do not have to sign this authorization in order to receive health care benefits from treating medical providers. I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof.

I understand that I have the right to revoke this authorization at any time and I understand once the information is disclosed, it may no longer be protected by Federal privacy law and may be re-disclosed. I also understand that I may revoke this authorization only in writing and sent by certified mail to the relevant Provider. The revocation will be effective only upon receipt, except to the extent the Provider has acted in reliance on the authorization, or the authorization was obtained by as a condition of obtaining insurance coverage and the insurer wishes to use the protected health coverage and the insurer wishes to use the protected health information to lawfully contest a claim. Further information on the right to revoke may be provided from time to time when requested by the patient to the provider's servicing office.

Notice of Privacy Practices:

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed. Please forward my Protected Health Information to:

Orthopaedic Solutions, LLC
10105 Banburry Cross Dr. Ste. 445 Las Vegas, NV 89144
Phone: (702) 475-4390 Fax: (702) 951-5456

_____	_____	_____
Print Name (Patient)	Signature	Date
_____	_____	_____
Print Name (Guardian, if minor)	Signature	Date

TOTAL SPORTS MEDICINE & ORTHOPEDICS

Medical Records – Request / Release of Information

I (Please Print)_____ give permission to Total Sports Medicine and Orthopedics to:

Release/Obtain:

☐ ALL MEDICAL RECORDS

☐ BILLING RECORDS

☐ OTHER (Please Specify):_____

Total Sports Medicine & Orthopedics

Office of Joseph Yu MD, Van Nguyen PA-C, and Andrew Trinh PA-C

Please Choose Method of Transmittal

☐ Fax to: (888) 634-8658 or other: _____

☐ Mail to: 10105 Banburry Cross Drive Ste. 445, Las Vegas, NV 89144

☐ Email to: _____

Requesting Medical Records

Facility: _____

Address: _____

Phone:_____ Fax: _____

Patient Name (Last, First): _____

Date of Birth: _____/_____/_____

_____	_____	_____
Print Name (Patient)	Signature	Date
_____	_____	_____
Print Name (Guardian, if minor)	Signature	Date

Clear Form Email