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Patient Registration

Today's Date: _____ Referred By: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)
Last Name: _____ First Name: _____Middle Initial: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Wk. #: _____
Email Address: _____
DOB: _____ Age: _____ Sex: _____ Marital Status: _____
Driver License #: _____ DL: State: _____ SS#: _____
*Employer Name and address: _____

Emergency Contact Name: _____
Relationship: _____
Phone: _____

Primary Care Physician: _____
Address: _____
Phone Number: _____

Preferred Method of Contact: _____
Email for Patient Portal: _____
DFW Sports Medicine may leave detailed messages or lab results on above number: Yes No

Preferred Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____

IF PATIENT IS A MINOR:
With Whom Does the Child Primarily Live? Both Parents Mother Father Other:_____
Under Whom is the Child's Insurance Policy: _____

Mother's (Guardian) Information:
Name: _____ DOB: _____
Address: ☐ Same as patient. If not, please fill address details below.
_____ City: _____State: _____ Zip:_____
Cell: _____ Home Phone:_____
Employer: _____ Occupation: _____

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Father's (Guardian) Information:
Name: _____ DOB: _____
Address: ☐ Same as patient. If not, please fill address details below.
_____ City: _____ State: _____ Zip: _____
Cell: _____ Home Phone: _____
Employer: _____ Occupation: _____

Non-Parental Consent (Others Authorized to bring in child)
Name: _____ Relationship: _____
Phone: _____ Access to the patient's records? Yes / No
Name: _____ Relationship: _____
Phone: _____ Access to the patient's records? Yes / No

Additional Contact Questions
If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction

_____

GUARANTOR INFORMATION: (List person or insured name responsible for bill use full legal name, no nicknames)
Relationship of Guarantor to Patient: Self: _____ Spouse: _____ Parent: _____ Other: _____
Last name, First: _____ SS#: _____
Address: ☐ Same as patient. If not, please fill address details below.
_____
City: _____ State: _____ Zip: _____
Home Phone #: _____ DOB: _____ Age: _____
Employer Name & Address: _____
_____ Phone #: _____

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INSURANCE INFORMATION: (Please allow staff to photocopy your insurance ID cards.)
IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:
Plan Name: _____ *Insured's Name: _____
Insured's SS#: _____ *Insured's Date of Birth: _____
*Policy / ID#: _____ *Group #: _____ *Eff Date: _____
Claims Address & Phone: _____

SECONDARY INSURANCE:
Plan Name: _____ *Insured's Name: _____
Insured's SS#: _____ *Insured's Date of Birth: _____
*Policy / ID#: _____ *Group #: _____ *Eff Date: _____
Claims Address & Phone: _____

REQUIERED FIELDS – PLEASE COMPLETE FOR BILLING & ATTACH COPY OF INSURANCE CARDS

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ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and DFW Sports Medicine is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to DFW Sports Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize DFW Sports Medicine to:

(1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments;
(2) process insurance claims generated in the course of examination or treatment; and
(3) allow a photocopy of my signature to be used to process insurance claims.

This order will remain in effect until revoked by me in writing.

I have requested medical services from DFW Sports Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

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Financial Policy

DFW Sports Medicine participates with many insurance plans. Each insurance policy is different and may have different coverage terms. Therefore, it is important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

Patient understands and agrees that he/she will be financially responsible for any and all charges for services not paid by the insurance for the visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician 's staff.

Patient understands and agrees it is his/her responsibility and not the responsibility of the physician or the physician's staff to know if insurance will pay for any medical service received.

Patient understands and agrees it is his/her responsibility to know if the physician seen is a contracted in-network provider recognized by the insurance company or plan. If the physician seen is not recognized by insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to the patient. Patients understands this and agrees to be financially responsible for all charges.

Patient understands and agrees it is his/her responsibility to know if the sports medicine physician of choice has been processed by the insurance company or plan. If you have requested a sports medicine physician that is not processed by your insurance company, it may result in claims being denied. Patient understands this and agrees to be financially responsible and make full payment.

Copayments and Deductibles
Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. Patient understands and agrees it his/her responsibility to know if his/her insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services rendered. These payments are expected to be made at the time of service. Payment may be made in cash, debit, or credit card. We also accept Health Savings Account (HSA) cards for payment. Checks are not accepted.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the office. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. In addition, you are responsible for any

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preventative services that are not covered by your insurance plan. We are happy to discuss arrangements for payment by installment if needed.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Patients Without Insurance Coverage
DFW Sports Medicine is happy to work with patients that prefer to pay directly for services or do not have insurance. For such patients, fees will be applied and paid in full prior to seeing the physician or on the day services are rendered.

Administrative Fee for Forms
If you or your child needs forms filled out, DFW Sports Medicine is happy to assist. A fee of $25 will be charged for the completion and signage of the form within 5 business days. If expedited services are needed, a fee of $50 will be charged and completion and signage of the form will be done within 3 business days.

Request of Medical Records
If you are needing a complete medical record for yourself, there is a $25 fee and $30 fee if records exceed 100 pages. There is no fee if records need to be transferred to another medical provider.

No-Show Fee
Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no-show fee of $50. Repeated no-shows will result in the patient or family being advised to transfer care out of the practice.

I have read, understood, and agree to the above policy.

_____

Patient/ Guardian/ Representative Printed Name

_____ _____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____ _____

Patient/ Guardian/ Representative Signature **Date**

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Medical Records Release Authorization

Patient's Name:_____
Address:_____
Phone:_____ DOB:_____ SSN:__XXX-XX-_____
Which records are needed:_____
Reason for transfer/request:_____

I, the undersigned, do hereby authorize and direct you to

( ) Furnish records **TO** DFW Sports Medicine from:
( ) Release records **FROM** DFW Sports Medicine to:

******IMPORTANT NOTICE: Per DFW Sports Medicine Healthcare Practice Policy, we only copy, print, mail or fax DFW Sports Medicine records. We do not copy, print, mail or fax other Doctor's medical records. Please contact your past doctor for these records.**

Write the Practice Name or Hospital Name/Physician name:
Name:_____
Address:_____
Phone:_____
Fax:_____

Check how records are to be received: Mail_____ Pick-Up_____ Fax_____

(If **all** records are requested, **DFW Sports Medicine will mail records**)

DFW Sports Medicine PLLC
4833 Medical Center Dr 6E, McKinney, TX 75069
Or
1850 Lakepointe Dr, Ste 700, Lewisville, TX 75057
Phone 469-645-0200
Fax 469-320-9550

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for cost for copies.

A copy of this authorization is as valid as an original and will expire 6 months from the date below.

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Medical Records Request Fees:

- **Print**- I understand that you may charge me a fee of up to $25 if I request my entire chart for personal use
- **Oversized Document**- I understand that you may charge me a fee of up to $30 if I request my entire chart for personal use and it exceeds 100 pages
- **NO CHARGE**- Any records that are to be released for the purpose of continuation of care to a designated physician or insurance company.

I UNDERSTAND THAT DFW SPORTS MEDICINE DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS OR FACILITIES.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

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No Show/Cancellation Policy
PLEASE READ CAREFULLY

DFW Sports Medicine strives to provide each patient with the highest quality care and service. To help the clinic operate at optimal level, we ask that you read and acknowledge the following policy:

1. Please provide our office with 24-hour notice to change/cancel an appointment. Patients who do not attend a scheduled appointment or do not provide a 24-hour notice to change the appointment will be responsible for a $50 no show/cancellation fee. This fee **CANNOT** be billed to insurance and must be paid at the time of the missed/changed appointment and prior to the next scheduled visit.

2. If you are more than 15 minutes late, your appointment will need to be rescheduled and a no show/cancellation fee will need to be collected for that visit.

3. Providing a 24-hour notice allows us to place another patient in your slot to receive needed treatment.

4. After missed three (3) appointment without notice, you may be placed on a same day scheduling policy for your treatment, not allowing you to schedule your treatments in advance or discharged from care.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand agree to the terms of this policy.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

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Credit Card Authorization Form

PATIENT NAME: _____

DATE OF BIRTH: _____

The purpose of this form is to authorize DFW Sports Medicine to retain a valid credit card number on file for you as a patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information. Please refer to our website www.dfwsportsmed.com for a copy of our Office Policies.

Your supplied credit card will be charged **ONLY** under the following circumstances:

1. DFW Sports Medicine reserves the right to charge the credit card listed below for all current patient balances, including co-pays (following insurance payments) and a receipt will be kept in your patient chart, unless directed to send the receipt directly to you. **This notice serves as your consent to being charged for all current patient balances on your account.**

2. lf you, as the patient, miss a scheduled appointment without a 24-hour notice to cancel or reschedule, DFW Sports Medicine reserves the right to charge the credit card listed below $50 for our standard no-show fee and a receipt will be sent to the current address on file. **This notice serves as your consent to being charged for any and all no-show fees.** As is customary, a representative from SHH will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appointment. lt is the patient's responsibility to ensure we have a correct and current telephone number on file.

3. lf we receive notice that a payment is returned to us for any reason, DFW Sports Medicine reserves the right to charge the credit card listed below a S30 returned check fee as well as a $25 processing fee. A receipt will be sent to the current address on file. **This notice serves as your consent to being charged for any returned payments.**

4. lf you, as a patient, request paper records we will provide to you, upon written request, a paper copy of your medical record. DFW Sports Medicine reserves the right to charge our base fee of S25 to provide you with a copy of your records and $30 if records exceed 100 pages. **This notice serves as your consent to being charged for medical records request.**

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5. lf you, as a patient, receive a Fee for Service, this includes any medications, labs, procedures, supplies and other services **NOT** covered by your insurance and offered to you by DFW Sports Medicine; we DFW Sports Medicine, reserve the right to charge the credit card listed below for the cost of the services rendered according to your insurance policy.

Other than the conditions mentioned above, under NO circumstance will DFW Sports Medicine charge your credit card for anything not discussed personally with you. ln conjunction with HIPPA regulations, all credit card information will be confidentially kept within your account in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed, & Accepted:

Having read this form and talked with the physician, and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X _____ _____
Patient/ Guardian/ Representative Signature **Date**

X _____
Staff Signature **Date**

NAME AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

DISC/MC/VISA #:_____

EXPIRATION DATE: _____ / _____

VERIFICATION CODE (3 or 4 digits): _____

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Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following: Since there is no credit card on file with DFW Sports Medicine, DFW Sports Medicine reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice. Please note, there may be a discretionary charge of $20 for this statement. It is your responsibility to send the amount due within 45 days of your statement to avoid being sent to collections and having your account closed with our practice.

X _____

Patient/ Guardian/ Representative Signature **Date**

X _____

Staff Signature **Date**

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Notice of Privacy Practices

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

PLEASE REVIEW CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY DFW SPORTS MEDICINE, PLLC WHETHER MADE BY THE COMPANY OR AN ASSOCIATED FACILITY.

Uses and Disclosures

Treatment. Your 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, 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.

Payment. Your health information may be used to seek payment from your health plan and from other sources such as 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, services provided, and the medical condition for which you are being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our company. For example, information on the services 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.

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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.

Additional Uses of Information
Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send your information that you may find interesting on the treatment and management of your medical condition. We may also send your information describing other health-related products and services that we believe may interest you.

Fundraising. Unless you request us not to, we may use your name and address to support our fundraising efforts, if any. If you do not want to participate in fundraising efforts, please check off the following box.

( ) Please do not use my information for fundraising purposes.

Individual Rights
You have certain rights under the federal privacy standards. These include the following and are explained in greater detail in the **PATIENT RIGHTS** section of this notice:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to who your protected health information has been disclosed
- the right to receive a printed copy of this notice

Duties of the Company
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlines in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices.

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Changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Rathna Nuti, MD
DFW Sports Medicine, PLLC
4833 Medical Center Dr 6E
McKinney, TX 75069
Or
1850 Lakepointe Dr, Ste 700
Lewisville, TX 75057

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is as noted above. You may call our Privacy Officer at 469-430-9380.

Effective Date
This notice is effective on or after January 1, 2016.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS COMPANY REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

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Right to Inspect and Copy
You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records or others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Privacy. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our denial be reviewed. Another licensed health care professional chosen by the company will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend
If you feel that the medical information we have about you in your record is incorrect or incomplete, they you may ask us to amend the information by following the procedure below. You have the right to request an amendment for as long as the company maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the company;
- is not part of the information which you would be permitted to inspect and copy; or
- is inaccurate and incomplete

Right to an Accounting of Disclosures
You have the right to request and “accounting of disclosures”. This is a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period no longer than six (6) years back and

may not include dates before January 1, 2016 (or the actual implantation date of the HIPPA Privacy Regulations). Your request should indicate in what form you want the list (ie. Paper or electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is expected from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing and your request must indicate:

- what information you want to limit;
- whether you want to limit our use, disclosure or both; and
- to whom you want the limits to apply (i.e., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voicemail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

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Acknowledgement of Receipt of Notice of Privacy Practices

DFW Sports Medicine, PLLC reserves the right to modify the right to modify the privacy practices outlined in its notice.

Signature
I have received a copy of the Notice of Privacy Practices from the company referenced above.

_____
Patient/ Guardian/ Representative Printed Name

_____
Relationship to patient (if signed by other than patient) **Witness (optional)**

_____
Patient/ Guardian/ Representative Signature **Date**

Please sign below **ONLY** if you are **DECLINING** your Notice of Privacy Practice.

I acknowledge that I have declined to receive of review the Notice of Privacy Practices offered by DFW Sports Medicine. I also understand that by signing I waive the rights listed in previous sections. I agree and understand that I do not have to sign this acknowledgement in order for me/the patient to receive treatment by DFW Sports Medicine.

_____
Patient/ Guardian/ Representative Printed Name

_____
Relationship to patient (if signed by other than patient) **Witness (optional)**

_____
Patient/ Guardian/ Representative Signature **Date**

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HIPAA & Confidentiality

It is the policy of DFW Sports Medicine to respect and protect the privacy of our patients, families, and employees. To that end, all patient related information is treated confidential.

HIPAA – HIPAA refers to the "Health Insurance Portability and Availability Act of 1996". This act led to the HIPAA Privacy Rule which went into effect in 2003. This privacy rule protects the unauthorized disclosure of any personally identifiable health information (also known as protected health information or PHI).

As a health care provider, we may share information for the purposes of:

Payment – example sending claims to an insurance company
Operations – example hiring a chart auditor to review our coding and billing practices
Treatment – example referring you or your child to a subspecialist requires sharing of information.

If PHI is to be disclosed for any other PURPOSE, the patient's, parents', or legal guardians' written authorization is mandatory. Additionally, when PHI is released, we will release only as much information as necessary and no more.

If PHI is to be released over the telephone, DFW Sports Medicine will verify the identity of the individual receiving the information. DFW Sports Medicine employees will, prior to disclosing PHI, ask specific questions that could only be answered by the patient, patient's family, and/or legal guardian such as patient's DOB or home address.

Signature of this document acknowledges that I have been offered and provided with a copy of DFW Sports Medicine's HIPAA policy which described how medical information may be used and/or disclosed. I also understand that I am entitled to be notified if there is a breech in this policy as it pertains to mine and/or my child's medical record.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

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FOR OFFICE USE ONLY:

I made a good faith effort to obtain a written acknowledgement of receipt of HIPAA policy from the above-named patient, but was unable to because:

_____ patient declined to sign this written acknowledgement

_____ other (specify): _____

Name and Title of Employee: _____ Date: _____

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Authorization to Release Protected Health Information

Patient Name:_____Date of Birth: ____/____ /_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse/Parent _____ Phone: _____
[ ] Child(ren) _____ Phone: _____
[ ] Other _____ Phone: _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me in (day) _____ between (time) _____

_____
Patient/ Guardian/ Representative Printed Name

_____
Relationship to patient (if signed by other than patient) **Witness (optional)**

_____
Patient/ Guardian/ Representative Signature **Date**

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Consent to Treat

I hereby give consent to DFW Sports Medicine and its designated staff to provide services as indicated by license and/or title including physical and/or mental health assessments or examinations, medical diagnosis or treatment as appropriate. I understand that this authorization is given in advance of any specific diagnosis or treatment.

If anyone other than a parent/legal guardian on file accompanies the child for a visit, a signed authorization is required, and the accompanying adult must have their valid photo identification.

I understand that if specific or new concerns are addressed, prescriptions given, or other situations which may have warranted a separate visit, this may incur an additional charge.

This authorization will remain in effect until revoked in writing by the patient, parent, or legal guardian.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

www.dfwsportsmed.com
Phone: (469) 430-9380 Fax: (469) 242-9539

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us info@dfwsportsmed.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 5 business days. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filled in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff, and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we way respond to your emails to us via email.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

DFW Sports Medicine

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Communications Policy

In order to stay in compliance with federal privacy regulations, and to prevent medical errors, we ask that **ALL** patients and their families follow our communications policy.

HOW TO COMMUNICATE HEALTH ISSUES

We feel that it is a privilege to practice medicine in a place where we are so closely tied to the community. Many of you know us socially or outside of this medical setting, however, we ask that you **do not contact us via our cell phones or personal emails** with medical questions, prescription request, etc. This is so that we can ensure that these requests do not get missed, and not because we are bothered by contact with our friends. ☺

If you let Dr. Nuti know your child/you are having medication side effects, or that you need a refill when at a school function, party, or sporting event, she may forget to document the conversation and valuable information may be lost, or texts may be missed.

All medical communications (prescription requests, appointment requests, medical questions of any kind, updates on a patients health condition) **MUST** be directed through our office phone number (469-430-9380).

I have read and understand this policy.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**

DFW Sports Medicine

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After-Hours Call Policy

Dr. Nuti is available for after-hours emergencies everyday, including holidays. She believes that taking these calls personally improves the quality of healthcare for her patients. In order for her to continue providing this service, we ask that you reserve after hours calling to her to true EMERGENCIES.

If you are considering an emergency room visit, or are concerned that your/your child's health condition cannot wait until the morning, please call our office number (469-430-9380) and you will receive instructions on how to contact Dr. Nuti.

Dr. Nuti will return the call within 30 minutes. If you do not hear from her within 30 minutes please place your call again.

PLEASE REMEMBER THIS SERVICE IS FOR EMERGENCIES ONLY, NOT MEDICAL QUESTIONS.

We ask that you do not call the doctor, after hours, for medical advice that can wait until the morning, medical refills, appointment rescheduling, etc.

Your compliance with this matter will assist us in being able to continue to provide this valuable service to our patients.

DFW Sports Medicine

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Phone: (469) 430-9380 Fax: (469) 242-9539

COVID-19 SCREENING QUESTIONNAIRE

In response to the recent Coronavirus (COVID-19) outbreak and the raised pandemic alert status by the World Health Organization (WHO), Rathna Nuti MD is taking precautions to lessen the spread of the virus. All patients must have a screening form completed prior to the visit.

Please review the following criteria:

	Yes	No
Have you or anyone in the household tested positive for COVID-19?		
Have you or anyone in the household been tested for COVID-19 and are awaiting results?		
Do you or anyone in the household have any of the following respiratory symptoms: fever, sore throat, cough, shortness of breath?		
Have you or anyone in the household recently lost your sense of smell or taste?		
Do you or anyone in the household have any GI symptoms? Diarrhea? Nausea?		
Even if you don't currently have any of the above symptoms, have you or anyone in the household experienced any of those symptoms in the last 14 days?		
Have you or anyone in the household been in contact with someone who has tested positive for COVID-19 in the last 14 days?		
Have you or anyone in the household traveled outside of the United States by air or cruise ship in the past 14 days?		
Have you or anyone in the household traveled within the United States by air, bus, or train within the past 14 days?		

By signing below, you certify that the answers above are true, you do not meet the criteria above, and that you have been provided with this information.

I HAVE REVIEWED THE ABOVE CRITERIA AND I DO NOT HAVE SYMPTOMS AS DESCRIBED.

_____

Patient/ Guardian/ Representative Printed Name

_____

Relationship to patient (if signed by other than patient) **Witness (optional)**

_____

Patient/ Guardian/ Representative Signature **Date**