SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

PATIENT REGISTRATION

Patient Information						
First Name		Last Name			Full Middle Name	
Nick Name			Other Last Name(s) Used			
Date of Birth	Age	Gender ☐ Male ☐ Female	SSN		Preferred Language	
Address		City		State	Zip	
Please Check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐	Fax		
Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Life Partner	Race ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other _____		☐ Asian ☐ White		Ethnicity ☐ Not Hispanic ☐ Hispanic ☐ Unknown	
Primary Care Provider		Phone Number				
How were you referred to our office?		Phone Number				

Responsible Party ☐ **Same as Patient**					
First Name	Last Name		MI	Date of Birth	
Address	City		State	Zip	
Please Check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐	Fax	
SSN	Driver's License	Relationship to Patient			

Employment/Student Information			
Employed FT ☐ PT ☐	Unemployed ☐	Retired ☐	Student FT ☐ PT ☐
Employer/School Name			
Employment Position		Work Phone	

If this visit is due to an accident complete the information below			
Employment Accident ☐	Auto Accident ☐	Other Accident ☐	Date of Accident:
Auto Insurance Carrier		Policy #	
Do you have an attorney? ☐ Yes ☐ No	Attorney's Name/Law Firm		Phone Number
Address	City	State	Zip

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

INSURANCE REGISTRATION

Insurance Information			
Primary Insurance		**Secondary Insurance**	
Insurance Co.		Insurance Co.	
Policy Holder's Name		Policy Holder's Name	
Policy Holder's Gender		Policy Holder's Gender	
Policy Holder's Date of Birth		Policy Holder's Date of Birth	
Relationship to Patient		Relationship to Patient	
Employer		Employer	
Policy #		Policy #	
Group #		Group #	

Medicare Patients Only		
Medical Number	Part A Effective Date	Part B Effective Date
Secondary Insurance Company	Plan Number	File Claim To: Medicare ☐ Secondary ☐

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physician and staff of Seivert Orthopedics & Sports Medicine, P.C. to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

I do hereby authorize and request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf, be paid directly to Seivert Orthopedics & Sports Medicine, P.C. for any medical or surgical services rendered to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers or the insurance company any information needed for this or related Medicare/Other Insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. I also hereby authorize Seivert Orthopedics & Sports Medicine, P.C. to release information requested by insurance company and/or its representatives

I am aware that I must update my information if there are any changes to be made. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependent regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses and attorneys' fees incurred to collect any amount I may owe.

I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (PLEASE PRINT) Relationship to Patient

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

MEDICAL REGISTRATION

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone Number	Phone Number
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy
Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medication

Medication Name	**Dosage**

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc)

☐ No known allergies

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (PLEASE PRINT) Relationship to Patient

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

COMMUNICATING WITH YOU

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, fax, and telephone, including leaving message on your answering machine/voice mail.**

Please check all boxes that you give Seivert Orthopedics & Sports Medicine, P.C. permission to use for your communications:

☐ You may contact me by telephone — Phone Number _____

☐ You may leave a message/voice mail that may contain confidential information — Phone Number _____

☐ You may contact me by mail

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1. Ph#:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information ☐ Emergency Contact
2. Ph#:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information ☐ Emergency Contact
3 Ph#:		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information ☐ Emergency Contact
4, Ph#		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information ☐ Emergency Contact

This request supersedes any prior request for communication of information I may have made.

_____ _____
Signature of Patient/Responsible Party — Date

_____ _____
Name of Patient/Responsible Party (PLEASE PRINT) — Relationship to Patient

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

PATIENT HISTORY AND PHYSICAL

Name _____ Date _____

Reason for today's office visit: _____

_____

_____

_____

List previous hospitalizations/surgeries (Include the Month/Year of surgery):

_____

_____

_____

_____

_____

	Patient	Family		Patient	Family
Eyes, Ears Nose, Throat			**Musculoskeletal**		
Glaucoma			Neck		
Cataracts			Back		
Thyroid			Joints		
Heart			**Skin**		
Hypertension			Eczema		
Lungs			**Neurological**		
Asthma			Epilepsy		
Emphysema			Migraines		
Tuberculosis			**Psychiatric**		
Gastrointestinal			Depression		
Ulcers			**Endocrine**		
Crohns					
Hernia			Diabetes		
Hepatitis			**Blood**		
Genitourinary			Lymphoma		
Bladder			**Allergy**		
Cancer			Food		
			Medicine		

4611 E. SHEA BLVD, SUITE 200 ● PHOENIX, AZ 85028 ● (602) 265-9900 ● FAX (602) 265-4130
SEIVERTORTHOPEDICS.COM

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. As a **courtesy** we will file claims to your insurance company. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your plan benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductibles(s), and then bill you for any amount determined to be your responsibility. The process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have no co-insurance charges, higher copayments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- We accept Workers' Compensation, Automobile Insurance and Medical Liens. We will file the claims to the appropriate insurance company. If for case is denied, we will attempt to file the claim to your medical insurance company. If for any reason your claim is denied by your medical insurance company, you will be responsible for all charges.
- Medical Liens will be filed to Maricopa County Lien office. Once your account has been cleared we will file a release letter to release the lien filed with the county.
- Self-pay patients will be responsible to pay fees at the time services are rendered unless previous arrangements have been made.

Any and all forms/paperwork from insurance companies and otherwise above and beyond your regular office visit will incur a charge of $40 per form billed directly to you.

****Missed appointment charges will be incurred, with <u>less than a 24 hour cancellation</u> at the rate of $60 per missed appointment which will be your responsibility and billed directly to you.**

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (PLEASE PRINT) Relationship to Patient

_____ _____
Office Representative Date

4611 E. SHEA BLVD, SUITE 200 ● PHOENIX, AZ 85028 ● (602) 265-9900 ● FAX (602) 265-4130
SEIVERTORTHOPEDICS.COM

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

Credit Card Payment Authorization Form

Sign and complete this form to authorize Seivert Orthopedic & Sports Medicine to make a debit to your credit/debit card listed below.

By signing this form you give us permission to debit your account for the amount indicated. This is permission for phone transactions only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Seivert Orthopedic & Sports Medicine to charge my credit/debit card
(full name)
account indicated below for payments made over the phone. This payment is for amount owed on my account for medical services rendered and will be specified when calling in.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for payments made over the phone. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

MICHAEL A. SEIVERT, D.O., FAOAO, FAOASM
BOARD CERTIFIED IN ORTHOPEDIC SURGERY
BOARD CERTIFIED IN SPORTS MEDICINE
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF ORTHOPEDICS
FELLOW AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 4611 E. Shea Blvd, Suite 200, Phoenix, Az 85028:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 4611 E. Shea Blvd, Suite 200, Phoenix, AZ 85028 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (PLEASE PRINT) Relationship to Patient

_____ _____

Office Representative Date