step up
SPORTS MEDICINE
GET BACK IN THE GAME

Patient Policies

FINANCIAL POLICY

Step Up Sports Medicine, PLLC is committed to providing you with the best medical care. To achieve this goal, you must have a clear understanding of our financial policy, which is important to sustain a professional relationship.

As a patient entering our practice, we will require identifying information, including a current Driver's License or State ID Card, and insurance ID cards.

Payment Methods: Accepts Cash, Visa, MasterCard, and American and Discover.

Uninsured or Self-Pay Patients: Estimated Payment is due in full at the time of service.

Insurance Billing: It is your responsibility to know your benefits both in and out of network and how they will apply to your treatment by the doctor. Step Up Sports Medicine, PLLC will follow the insurance contract guidelines for billing and collections. Please verify if Step Up Sports Medicine, PLLC is a preferred provider with your insurance plan prior to receiving services.

HMO & EPO Patients: You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment. You will be fully responsible for all charges incurred if you receive treatment without obtaining authorization and/or prior approval.

Eligibility: Athena One is a system Step Up Sports Medicine, PLLC has adopted to verify real-time eligibility with your insurance **and its use is required at each visit**. In addition to eligibility, the system is designed to improve transparency around the costs of care. It does so by providing Step Up Sports Medicine, PLLC patients with estimates of patient responsibility based on information received through integration (gateway) with your insurance company and the day's charges.

Co-Pay, Deductible and Share of Cost: Athena One will also be used to **collect patient responsibility.** co-pays at the time of visit, as well as share of cost and deductibles at the time of claim processing.

Extended Office Hours: We bill approved CPT codes for services provided in the office during regularly scheduled evening, weekend, or holiday hours, in addition to basic service. 99051 CPT code is for providing services when the office has posted hours and is open later and more days than the standard M-F business hours. In some instances, you may be responsible for some or all of the associated fees not covered by your insurance provider.

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New Patient Packet

Thank you for choosing Step Up Sports Medicine. Our office looks forward to serving you.

Prior to your appointment

- Please complete the attached New Patient paperwork. Be sure to read the Financial Policy, Notice of Privacy Practices, and Patient Policies prior to completing the acknowledgement.
- If for any reason you are unable to keep your confirmed appointment, please call our office to reschedule your visit to suit your needs.
- Note our telephone hours are 10:00am – 7:00pm M-F, someone will be happy to assist you by calling (817)668-3222.
- Visit Step Up Sports Medicine's web-site at www.stepupsportsmed.com to become more familiar with our office and visit.

The day of your appointment

- There are additional steps to the registration process that must be completed at the office on your fist visit, so please be sure to arrive 30-minutes early with your completed paperwork so that you can make your appointment time.
- Bring your insurance card(s) or a legible copy and a photo ID. If for any reason you do not have a copy of your insurance card, please contact your insurance carrier prior to your arrival and bring proof of eligibility to your appointment.
- Means for satisfying the co-payment required by your insurance company or un-met deductible.

Thanks again for choosing Step Up Sports Medicine

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3020 Corporate Court, Ste 400
Flower Mound, TX 785028
(817)668-3222

PATIENT INFORMATION

NAME (Last, First Middle)	SS#	BIRTHDATE	SEX
LOCAL ADDRESS	CITY, STATE, ZIP		
HOME PHONE	DAY PHONE	EMAIL ADDRESS	
PRIMARY PHYSICIAN	REFERRING PHYSICIAN	REFERRAL SOURCE	

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	POLICY #
ADDRESS OF INSURANCE COMPANY	GROUP #
CITY, STATE, ZIP	PHONE #
NAME OF INSURED PARTY (MAIN SUBSCRIBER)	RELATIONSHIP TO PATIENT
ADDRESS OF INSURED PARTY	CITY, STATE, ZIP
DATE OF BIRTH OF INSURED PARTY	SS # OF INSURED PARTY	PHONE # OF INSURED PARTY

SECONDARY INSURANCE INFORMATION (If Applicable)

NAME OF INSURANCE COMPANY	POLICY #
ADDRESS OF INSURANCE COMPANY	GROUP #
CITY, STATE, ZIP	PHONE #
NAME OF INSURED PARTY (MAIN SUBSCRIBER)	RELATIONSHIP TO PATIENT
ADDRESS OF INSURED PARTY	CITY, STATE, ZIP
DATE OF BIRTH OF INSURED PARTY	SS # OF INSURED PARTY	PHONE # OF INSURED PARTY

EMERGENCY CONTACT

NAME	PHONE #
RELATIONSHIP TO PATIENT	SECONDARY PHONE #

I hereby authorize and consent to examination and treatment as deemed necessary by physicians of Step Up Sports Medicine, PLLC. I authorize the release of information to my insurance carrier should it be necessary. I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Step Up Sports Medicine, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all information necessary to secure payment. The undersigned agrees to pay any costs incurred by Step Up Sports Medicine, PLLC in the collection of amounts due including, but not limited to, reasonable attorney's fees.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Patient Policies

Referrals for Physician & Ancillary Services: When being referred to an outside organization as part of your care (i.e., Physical Therapy, MRI, DME Providers, Physicians, etc.), Step Up Sports Medicine, PLLC does not verify if these organizations are preferred providers with your insurance plan. Please verify this directly with your insurance company prior to obtaining services.

If you choose to seek care at a non-preferred/non-participating provider for ancillary services, you may be responsible for higher copayments and costs in excess of your insurance company's allowable amounts, up to the non-preferred provider's total billed charges. Patients accept the financial responsibility for any additional cost for service when obtaining services from a non-preferred/non-participating provider regardless of being referred by Step Up Sports Medicine, PLLC. For assistance locating a preferred provider for ancillary services, you may contact your insurance company directly.

Returned Checks: A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.

Outside Collections and Payment Plans: If unable to make payment in full, contact the billing department immediately to make payment arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus any collection agency charges and reasonable attorney's fees. If your account becomes delinquent or is referred for collections, your provider and/or any collection agent of your provider has authorization to obtain your credit report to assist them in the collection of your bill.

NOTICE OF PRIVACY PRACTICES

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

The Notice of Privacy Practices explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. The policy in its entirety can be requested from the receptionist or found on our web-site. Please review it carefully. For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
    - Treatment
    - Payment
    - Health Care Operations
    - Notifications and Special Circumstance and the Law
    - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.

Patient Policies

PRESCRIPTION REFILL POLICY

The patient is responsible for knowing when medication(s) will need to be refilled. The specific protocol is outlined below. All patients are requested to execute acknowledgement that they have read the protocol and agree with its requirements.

- It is the policy of Step Up Sports Medicine, PLLC that medications will only be refilled between 10:00 am to 6:00pm, Monday – Friday.
- **No prescription refills will be given on Saturday, Sunday or holidays.**
- At least 48 - 72 business hours are needed to process a refill request.
- Early refills will not be authorized.
- Medications or prescriptions will not be replaced if lost or misplaced.
- If your physician is not in the office, or is unavailable, you may have to wait until he/she returns for medication refills to be authorized.
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 3-6 months.

Controlled substances/narcotic prescriptions require a follow up appointment every 30-90 days. Step Up Sports Medicine, PLLC does not routinely prescribe narcotics on a long-term basis, nor do we administer narcotics by injection at our office. Individuals who are seeking "pain killers" for chronic use will be advised to make an appointment with a pain management or primary care physician.

MEDICATION ACKNOWLEDGEMENT OF DRIVING IMPAIRMENT

(Not applicable for patients under 16 years of age)

While you are under the care of your Physician, you may be prescribed medication that could impair your ability to operate a motor vehicle, heavy machinery or equipment.

Please refrain from operating a motor vehicle under the influence of prescribed medications that impair judgment. Arrange for proper transportation and use the proper precautions when taking prescribed medications. If you have any questions, please ask your Physician or your pharmacist.

Patient Policies

DME ACKNOWLEDGMENT OF DRIVING IMPAIRMENT

(Not applicable for patients under 16 years of age)

While under the care of your Physician, you may be fitted into Durable Medical Equipment, or DME (Cain, Walking Boots, Shoulder Slings, etc.). While the DME is to be utilized to protect or support your condition, by wearing the DME, it may impair your ability to operate automotive vehicles.

You might not be able to operate a vehicle safely due to the use of your DME, please arrange for proper transportation and take the proper precautions. If you have any questions regarding this matter, please ask your Physician.

DIAGNOSTIC TESTING RESULTS

While under the care of a Physician/Provider with Step Up Sports Medicine, PLLC you may be sent to have diagnostic testing performed (MRI, CT-scan, bone scan, lab work). It is the patient's responsibility to return to the office to receive the results of any diagnostic testing. Most testing is completed at an outside facility. It is the patient's responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician's office prior to the follow up appointment. Reports may be faxed to (817) 668-3200. Step Up Sports Medicine, PLLC is able to directly access testing performed at some facilities, please verify with staff to confirm if they have access to the facility if you want us to obtain records.

ORTHOPEDIC/ PRIMARY CARE SPORTS MEDICINE OPIOID PAIN MANAGEMENT AGREEMENT

In the course of your treatment, your provider may prescribe a controlled substance, which is a type of medication that is regulated by State and/or the Federal Government. By accepting the prescription, you are agreeing to follow the Orthopedic Opioid Pain Management Agreement. The purpose of the Agreement is to prevent misunderstandings about certain medications and to help you and your provider comply with the laws regarding controlled pharmaceuticals.

I, the patient, understand that I have the following responsibilities:

- I am aware that there is a risk of addiction to opioid/narcotic pain medications. I have honestly informed my physician of the complete history of my opioid past.
- I will take the medications only at the dose, frequency and route as prescribed, which includes by mouth, IV, injection or as specified by my physician. I will not increase or change medication frequency without the approval of my provider.
- I understand that while I am under the care of my physician at Step Up Sports Medicine, PLLC and as part of the coordination of my care, I will disclose and discuss all Opioid prescription medication I am taking from other physicians.
- I will inform my provider of all other medications that I am taking.
- I will protect my opioid/narcotic pain prescriptions and medications. I will place them in a secure location to prevent theft. I understand that lost/or destroyed medications will not be replaced.
- I will not share, sell or trade my opioid/narcotic pain medications with anyone. I understand this is a violation of federal and state law.

I understand that my provider at Step Up Sports Medicine will comply with the State of Texas guidelines and periodically check the DEA database to ensure compliance.

Patient Policies

By signing below, you are acknowledging that you have received, read, and agree to Step Up Sports Medicine's:

Financial Policy (attached)

_____ I have read the Financial Policy. I understand and agree to this Financial Policy.
Initials

Notice of Privacy Practices (attached)

_____ I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal
Initials copy of the Privacy Practices will be available per my request.

No Show Policy (attached)

_____ I hereby acknowledge the receipt of the Notice of Privacy Practices. A personal
Initials copy of the Privacy Practices will be available per my request.

Prescription Refill Policy (attached)

_____ I have read the Prescription Refill Policy. I understand and agree to this
Initials Prescription Refill Policy.

Medications Acknowledgement of Driving Impairment (attached)

_____ I have read and understand the Medications Acknowledgment of Driving
Initials Impairment. (Not applicable for patients under 16 years of age)

DME Acknowledgement of Driving Impairment (attached)

_____ I have read and understand the DME Acknowledgment of Driving Impairment.
Initials (Not applicable for patients under 16 years of age)

Acknowledgement of Diagnostic Testing Results (attached)

_____ I have read and understand the Diagnostic Testing Results.
Initials

Acknowledgement of Orthopedic/ Primary Care Sports Medicine Opioid Pain Management Agreement (attached)

_____ I have read and understand the Orthopedic Opioid Pain Management Agreement.
Initials

Signature of Patient or Responsible Party Printed Name Date

<u>Use or Disclosure of Personal Health Information Authorization</u>

I authorize the release of my patient health information to the following personal contacts (Spouse, Child, Assistant, etc.). I understand it is my responsibility to notify Step Up Sports Medicine, PLLC of any changes in the information below.

_____

Name Relationship
Phone #:

☐ Appointment Information
☐ Treatment Information
☐ Billing Information

_____

Name Relationship
Phone #:

☐ Appointment Information
☐ Treatment Information
☐ Billing Information

Patient Policies

I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer Step Up Sports Medicine,PLLC 3020 Corporate Court, Ste. 400, Flower Mound, TX 75028

Dear Patient,

Legislation has recently been enacted that requires healthcare facilities to adopt an Electronic Medical Records system and utilize the system to report specific data. The following questions are to fulfill this requirement.

Step Up Sports Medicine would like to assure you that your answers to these questions will have absolutely no impact on your care. You may opt to not answer any question by checking or writing "Decline to Answer."

RACE

- ☐ African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic
- ☐ Pacific Islander
- ☐ White
- ☐ Other
- ☐ Decline to Answer

ETHNICITY

- ☐
- ☐ Hispanic origin
- ☐ Not Hispanic origin
- Decline to Answer

Primary Language _____

Thank you,

Step Up Sports Medicine

Patient Policies

Patient Health History

Date: / /

Patient's Name Date Reviewed: Physician Initials

Name:_____Date of Birth:_____/_ /_____Age: _____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: ❑ F ❑ M Height:_____Weight:_____Primary Language:_____Do you need an interpreter? _____

Referred here by (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Professional

Name of person making referral: _____

Primary Care Physician:_____Internist:_____ Cardiologist: _____

Have you had a recent medical evaluation by one of these doctors?_____Name of Doctor: _____

Past Medical History

☐ Cancer Type:_____	☐ Anemia	☐ Jaundice	☐ Epilepsy
☐ Goiter	☐ Emphysema	☐ Pneumonia	☐ Rheumatic fever
☐ Cataracts	☐ Heart Problems	☐ HIV/AIDS	☐ Colitis
☐ Nervous Breakdown	☐ Leukemia	☐ Glaucoma	☐ Psoriasis
☐ Bad Headaches	☐ Diabetes	☐ Asthma	☐ Arthritis
☐ Kidney Disease	☐ Stomach Ulcers	☐ Stroke	☐ Childhood Arthritis
☐ High Blood Pressure	☐ Gout	☐ Tuberculosis	

In the past 4 weeks, have you had a cough, cold, sore throat or bronchitis that required treatment? _ Do you now or have you ever had any of the following? (If yes, check box)

List any other conditions you have had that are not already noted

_____

_____

_____

Current Medications (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements)

Drug Allergies: Yes_____No_____To What? _____
Type of Reaction:_____

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?	Please check: Helped? A Lot All	Some	Not At
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑

5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

Have you used blood thinners, such as Coumadin, Heparin, Aspirin, Ibuprofen, Aleve, or Plavix, with in the past 2 weeks? _____
Have you ever taken steroids, such as Prednisone or Medrol, by mouth?_____If yes, when and for how long? _____ Do you take medication for Osteoporosis such as Fosamax, Actonel, or Boniva? _____
Date of last EKG_____/_____/_____ Date of last Blood draw_____/_____/_____ Date of last Chest X-ray_____/___/_____
_____

List All Surgeries	Year	Reason
1.		
2.		
3.		
4.		
5.		

Social and Family History

Have you ever smoked? □ Yes □ No Quantity/Amount:_____If quit, how long ago? _____ Do you drink alcohol? □ Yes □ No number per week _____Has anyone ever told you to cut down on your drinking? □ Yes □ No

Do you use recreational drugs, such as marijuana, cocaine, meth? □Yes □No If yes, please list_____

Do you know of any blood relative who has or had any of the following? (Check and indicate relationship)

□ Cancer _____ □ Heart Disease _____ □ Rheumatoid Arthritis_____□ Tuberculosis _____
Type_____
□ Leukemia _____ □ High Blood pressure _____ □ Osteoarthritis_____□ Diabetes _____

□ Stroke_____□ Bleeding tendency _____ □ Asthma_____□ Goiter _____

□ Colitis _____ □ Alcoholism _____ □ Psoriasis_____□ Autoimmune Disease _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

CONSTITUTIONAL

❑ Recent weight gain amount _____
❑ Recent weight loss amount _____
❑ Fatigue
❑ Weakness
❑ Fever

Eyes

□ Loss of Vision
□ Double or blurred Vision
❑ Itching eyes

EARS–NOSE–MOUTH–THROAT

❑ Bleeding gums
❑ Ringing in ears
❑ Loss of hearing
❑ Nosebleeds
❑ Runny nose
❑ Sores in mouth
❑ Loss of taste
❑ Dryness of mouth
❑ Frequent sore throats
❑ Difficulty in swallowing

CARDIOVASCULAR

❑ Pain in chest
❑ Heart murmurs
❑ Irregular heart beat
❑ Sudden changes in heart beat
❑ High blood pressure

MUSCULOSKELETAL

❑ Morning stiffness Lasting how long?
❑ Joint pain
❑ Muscle weakness
❑ Muscle tenderness
❑ Joint swelling
List joints affected in the last 6 mos.

GASTROINTESTINAL

❑ Nausea
❑ Vomiting of blood or coffee ground material
❑ Stomach pain relieved by food or milk
❑ Blood in stools
❑ Jaundice
❑ Persistent diarrhea
❑ Black stools
❑ Heartburn
□ Increasing constipation

GENITOURINARY

□ Difficult Urination
□ Pain or burning on urination
❑ Rash/ulcers
❑ Blood in urine
❑ Pus in urine
❑ Cloudy, "smoky" urine
❑ Discharge from penis/vagina
❑ Getting up at night to pass urine
❑ Sexual difficulties
❑ Vaginal dryness

RESPIRATORY

❑ Shortness of breath
❑ Difficulty in breathing at night
❑ Wheezing (asthma)
❑ Swollen legs or feet
❑ Cough
Coughing up blood

INTEGUMENTARY (SKIN AND/OR BREAST)

❑ Easy bruising
❑ Redness
❑ Rash
❑ Hives
❑ Hair loss
❑ Tightness
❑ Nodules/bumps
❑ Color changes of hands or feet in the cold

NEUROLOGICAL SYSTEM

❑ Headaches
❑ Dizziness
❑ Night sweats
❑ Sensitivity or pain of hands and/or feet
❑ Memory loss
❑ Fainting
❑ Muscle spasm
❑ Loss of consciousness

HEMATOLOGIC/LYMPHATIC

□ Transfusion? When
❑ Swollen glands
❑ Tender glands
❑ Anemia
❑ Bleeding tendency

PSYCHIATRIC

□ Excessive worries
❑ Easily losing temper
□ Anxiety
❑ Depression
❑ Difficulty falling asleep
❑ Difficulty staying asleep

ENDOCRINE

❑ Excessive thirst

ALLERGIC/IMMUNOLOGIC

❑ Frequent sneezing
Increased susceptibility to infection