LEMAK
sportsmedicine&orthopedics

720 Montclair Road • Suite 101 • Birmingham, AL • 35213 • (205) 397-5200

Authorization for Medical Treatment: The undersigned will be informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Lemak Sports Medicine. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Lemak Sports Medicine will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Lemak Sports Medicine is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopedic technicians and/or coaches. I also authorize Lemak Sports Medicine to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Lemak Sports Medicine for application on the patient's bill. The undersigned and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by a specialist and by physicians for whom Lemak Sports Medicine is authorized to bill. Should the account be referred to an attorney for collection, the undersigned agrees to pay all costs of collections, including reasonable attorney fees of one third of the balance. All delinquent balances shall bear interest at the legal rate.

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Miscellaneous Provisions: I understand that under no circumstances will Lemak Sports Medicine be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR ONE AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

_____ _____

Undersigned (Patient's Signature) Signature - If signed by Undersigned's Authorized Agent

_____ _____

Witness Relationship to Undersigned

_____ _____

Witness - Need Only if Signatures are Made By Mark (X) Month Day Year Time (AM/PM)

Date and Time of Signing

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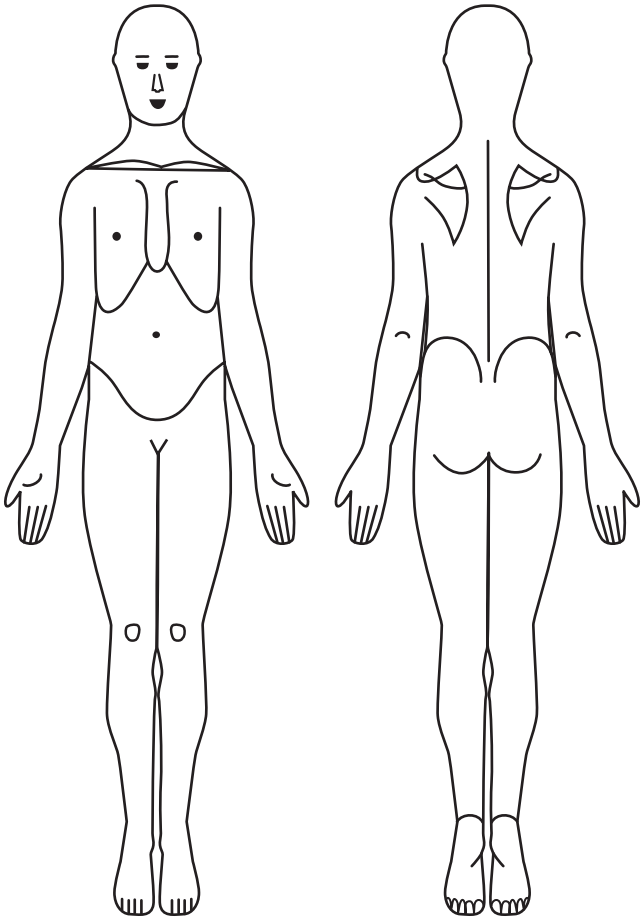
Patient Name: _____ Date:_____

PLEASE CIRCLE WHAT BODY PARTS YOU HAVE ISSUES WITH



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Today's Date: _____ **Email:** _____

Name: _____
(Last) (First) (MI) (Nick Name)

Marital Status: _____ **Sex: M F Date of Birth:**___/___/__ **SS#**___/__/____

Address: _____
Street Number or P.O. Box City State Zip

Home Phone: ( ) _____-_____ **Work:** ( ) _____-_____ **Cell:** ( ) _____-_____

Emergency Contact: _____ ( ) _____-_____
Name and Relationship of person outside Immediate Home Phone Number

Name of Spouse: _____**Spouse Employer:** _____

Patients Employer: _____

School:_____**Sport:**_____

Body Part: _____ **Left** _____ **Right**_____
Date of Injury/Accident Occurred: _____/_____/_____
How did injury occur: _____
Drug Allergies: _____

Primary Insurance: _____**Secondary Insurance:** _____

Policy Holders Name:_____**Policy Holders Name:** _____

Relationship to Patient:_____**Relationship to Patient:**_____

DOB:____/____/____ **SS#** ___/___/_____ **DOB:**____/____/____ **SS#:**___/___/_____

Contract # _____ **Grp#**_____ **Contract #** _____ **Grp#**_____

Policy Holders Employer:_____ **Policy Holders Employer:** _____

Is this a WORKMAN COMPENSATION CASE? Yes___ **No**___ **If yes, please provide the following:**

Date Of Injury: _____/_____/_____ **Employer:**_____

Work Comp Carrier: _____ **Address:** _____

List any Coach, Trainer, or Doctor and Complete Address that you want to receive a report.

Doctor:_____

Coach/Trainer: _____

Medical History

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current Medications: Please list *ALL* medications.

	Medication	Dose	Frequency		Medication	Dose	Frequency
1.				4.			
2.				5.			
3.				6.			

Past Surgeries: Please list past surgeries in chronological order.

	Type of Surgery	Year		Type of Surgery	Year
1.			3.		
2.			4.		

Family Medical History: Please list medical illness affecting your immediate family, e.g., parents and sibling.

	Disease	Family Member		Disease	Family Member
1.			4.		
2.			5.		
3.			6.		

Social History: Check appropriate line and fill in blanks.

Married ___ Single ___ Divorced ___ Widowed ___ Other ___ Alcohol ___

Alcohol: Occasional ___ Daily ___ Heavy ___ No consumption ___

Tobacco: Yes ___ No___ Years Used ___ Packs Per Day ___ Drugs ___

General History: Please check if any apply.

GENERAL

__Weight Change
__Fever or Chills
__Night Sweats
__Urinary Frequency
__Bleeding
__Lumps or Masses
__Dizziness or Fainting
__Itching or Rash
__Diabetes Mellitus
__Thyroid Problems
__Cancer

CARDIOVASCULAR

__Heart DX/Pain
__Hypertension
__Mitral Valve Prolapse
__Thrombophlebitis

RESPIRATORY

__Cough/Sputum
__Rheumatic Fever
__Tuberculosis
__Pleurisy Pneumonia
__Asthma

MUSCULOSKELEAL

__Backache
__ Joint Pain
__Joint Swelling

BREAST

__Lumps
__Pain
__Discharge

EAR-EYES-NOSE-THROAT

__Visual Change
__Hearing Change
__Tinnitus
__Dentures
__Bleeding Gums
__Hoarseness

GENITOURINARY

__Urinary Infections
__Incontinence
__Veneral Disease
__Menopause

NEUROLOGIC

__Seizures
__Paralysis
__Numbness
__Weakness

GASTROINTESTINAL

__Dysphasia (Difficulty in swallowing) __Nausea & Vomiting __Jaundice __Hepatitis

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH:_____ **SSN:** _____

PATIENT ADDRESS: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed (must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

_____

_____

Information that ***may not be used or disclosed:***

_____

_____

The name or other specific identification of the person(s), or class of persons, ***authorized to make the requested use or disclosure:***

_____

_____

Expiration date or an expiration event (must relate to the individual or the purpose of the use or disclosure):

_____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognized that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____

How did you hear about Lemak Sports Medicine? (check one)

Name **Contact Info**

__ Physician: _____

__ School/Coach/ Trainer: _____

__ Friend/Relative: _____

__ Direct Mail __ Yellow Pages __ TV __ Radio __ Newspaper __ Internet

__ Other: _____