®

4989 Peachtree Parkway - First Floor ~ Peachtree Corners, GA 30092
770-713-6480 Fax: 770-234-6292

Acknowledgment of Receipt of Privacy Practices and Patient Rights

I am aware that Sports Medicine Consulting Notice of Privacy Practices and Patient's Rights are available to me on the website www.sportsmedconsulting.com. I will notify the practice manager if I am unable to access these documents or if I have any questions.

Please Print Patient Name or Guardian Name and Relationship in box below.

Please Print and Sign Patient's Name

I am the parent/guardian of this patient _____

Date:_____

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Sports Medicine Consulting Cancellation Policy

If I need to cancel or reschedule my appointment, I acknowledge and agree to notify the office of this cancellation 24 hours or more prior to my appointment. If I cancel in less than 24 hours prior to my scheduled appointment, I acknowledge and agree that I will be responsible for a $85 charge. The exception to this is if I or a family member I care for is suddenly ill on the same day of my appointment and I can provide documentation from a healthcare provider of this or if I am called to active duty military.

This policy is in place to cover the day to day business expenses required to remain in business. Once a patient is scheduled, resources are mobilized including staff, equipment, supplies as well as the physician to help serve you.
Thank you, in advance, for your understanding so that we can remain in business to serve you.

Sports Medicine Consulting

Please Print and Sign Patient's Name

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COVID - 19

1. In the last 14 days, have you experienced any of the following symptoms? Fever above 98.6 degrees F (37 Degrees Celsius) OR Lost Sense of Smell OR Lost Sense of Taste OR Sore Throat OR Cough OR Felt feverish OR Shortness of breath ?

2. In the last 30 Days, have you been in contact with individuals confirmed with Coronavirus, quarantined for suspected Coronavirus, tested positive for Coronavirus once or more than once? Please answer Yes or No.

3. Have you traveled anywhere outside of the US or to a US or Non-US Coronavirus outbreak area within the last 14 days? (Please answer Yes or No)

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Credit Card Authorization Form

CREDIT CARD AUTHORIZATION for NO SHOW/LATE CANCELLATION FEES · INSURANCE COPAYS & DEDUCTIBLES

In order to provide you and other patients the best possible care, a minimum of 24 hours notice is required to cancel or reschedule appointments.

1. I understand the importance of notifying my physician at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $80. I understand that I will be charged a No Show fee of $80 for failing to call and/or failing to show for my scheduled appointment without giving a minimum of 24 hours notice.
2. I give Christopher R. Sellars, DO, LLC / Sports Medicine Consulting the authorization to charge my credit card $80 for each missed appointment where 24 hours notice is not given. This credit card will also be used for all fees that have not been paid within 60 days (unless other arrangements for payment have been agreed upon in writing between me and my physician's office). I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees). I understand that I may revoke this agreement at any time by providing a request in writing.

Cardholder's Name:

Credit Card Number:

Expiration Date:

CVV/Security Code:

I am requesting that this card be used for payment of services (co-pay & fees):

[ ] YES [ ] NO

Please Print and Sign Patient’s Name

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Demographic and PCP Form

Patient Name and Date of Birth:

Patient Social Security Number:

Patient Gender:

Patient Address: Street

City/Town, State, Zip

Patient Contact Number: Mobile and Home numbers

Patient Email:

Emergency Contact: Name and Relationship to Patient.

Emergency Contact Number(s):

Pharmacy Name and Address

Pharmacy Phone Number

Demographic and PCP Form (continued)

Primary Care Physician Name

Primary Care Physician Address: Street and Building and Suite Number

Primary Care Physician City, State, Zip

Primary Care Physician Phone Number

Please Print and Sign Patient's Name

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HPI Form

Please answer the following questions in the text boxes below. Please sign the signature box.

Height/ Weight:

Reason for Visit/Chief Complaint:

Location of Pain: Right Left Bilateral _____

Pain Level, From 0 to 10, (0= No pain at all; 10 = Worst Possible Pain)

Exacerbating Factors (ie, what make your pain worse?) Examples: bending extending sitting walking running stair climbing descending stairs biking running other etc.

Alleviating Factors (ie, what makes your pain better?): Examples: stretching rest exercise walking standing sitting changing positions other etc.

Duration of pain: number of weeks, months or years?

Quality of pain: Sharp Dull Achey Radiating etc.

Referring Physician:

Please Print and Sign Patient's Name

I am the parent/guardian of this patient _____

Date:_____

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Method of Payment/ Insurance Information Form

If you are Self Pay, please complete answer Yes in section (a) and then fill in (b) and sign the next signature box. Skip section II.

If you are using insurance for payment, Please skip (a) and (b) and proceed to Section II.

(a) Are you a Self Pay Patient?

Please Print and Sign Patient's Name

I am the parent/guardian of this patient _____

Date:_____

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Insurance Information Form

Primary Insurance Name and ID Number:

Primary Insurance Group Number and Group Name:

Primary Insurance Subscriber Name and Subscriber Date of Birth and Copay Amount:

Secondary Insurance Name / ID Number and Group Number:

Secondary Insurance Subscriber Name and Subscriber Date of Birth and Copay Amount:

I authorize the release of medical or other information necessary for my course of treatment and to process health insurance claims.

I hereby assign benefits to be paid on my behalf to the physician and facility that renders services to me.

The above information is all true to the best of my knowledge.

Please Print and Sign Patient's Name

I am the parent/guardian of this patient _____

Date:_____

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Telemedicine Consent Form

1. The purpose of this form is to obtain your consent and understanding to participate in telemedicine in connection with the services rendered by Sports Medicine Consulting.
2. My health care provider has explained to me how the video conferencing technology will be used and how it differs from a direct patient/health care provider visit.
3. I understand there are potential risks to using this technology that include interruptions, unauthorized access and technical difficulties.
4. I understand that my healthcare information may be shared with other individuals for treatment, scheduling and billing purposes. A non-medical technician may also me present during the consultation in order to operate the audio video equipment. Video and/or audio recordings may be retained of the visit. Everyone involved will maintain the privacy and security of my information to the best of their ability. I do understand that the services utilized in emergent situations may not provide the level of security necessary to be certain that my data will always be private and secure.
5. All existing laws pertaining to my access to my medical records apply to this telemedicine visit.
6. I further understand that I may terminate the consultation and revoke this consent at any time.
7. I have had the alternatives to telemedicine consultation explained to me. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
8. I understand that billing may occur from both my practitioner and as a facility fee from the site.
9. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to utilizing telemedicine. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language which I understand.

By signing this form, I certify that I have read or had this form explained to me
-That I fully understand its contents including the risks and benefits of using telemedicine.
-That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Please Print and Sign Patient's Name _____
I am the parent/guardian of this patient _____
Date:_____

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SPORTSMEDICINE
CONSULTING

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Client/Patient Email and Text Messaging Consent

The following is information regarding the risks of communication via text messaging (eg, SMS) and email, guidelines for text messaging and email communication and documentation of your voluntary consent for communication with you via text messaging and email.

1 Manner of use of text messaging and email communication:

1. Risks of using Tex (SMS) and Email for communication: Using electronic transmission of patient information by email and/or text messaging has a number of risks that patients should consider prior to authorizing the use of email and/or text messaging. These include, but are not limited to, the following risks:

a. Email and text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

b. Senders can easily misaddress an email/text message and send information to an undesired recipient.

c. Backup copies of emails and text messages may exist even after the sender/recipient has deleted their copy.

d. Employers and Online Services (email or telephone provider) have the right to inspect emails/text messages sent through their systems. Email and text messages can be intercepted, altered, forwarded or used without authorization or detection.

e. Email and text messages can/may be used as evidence in court.

f. Email and text messages may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and text messages cannot be guaranteed, but reasonable means will be used to maintain security and confidentiality of email and text information sent and received. Sports Medicine Consulting is not liable for improper disclosure of confidential information that is not caused by Sports Medicine Consulting intentional misconduct.

a. In a Medical Emergency, Do NOT Use Email or Text Messaging, Call 911. If you have an urgent problem during regular business hours, call 770-713-6480. Urgent messages or needs should be relayed via telephone communication.
b. We use text messaging and email to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of you medical record. You have the same right of access to such communications as you do to the remainder of your medical record.
c. Email and text messaging is not appropriate for urgent or emergency situations. Sports Medicine Consulting and its representatives cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. If you have not heard back within 48 hours, please call our office to follow up and inquire if we've received your message.
d. Please speak with someone in our office to discuss complex and/or sensitive situations rather than send emails or text messages regarding such situations. Emails and text messages may be filed into your medical record.
e. Email and text messages should be concise. The patient/parent/legal guardian should call the office to discuss complex or sensitive situations and/or to schedule any appointments.
f. You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
g. Sports Medicine Consulting and its representatives will not forward patient/parent/legal guardian's emails and/or text messages without their written consent, except as authorized by law.
h. Sports Medicine Consulting and its representatives are not liable for breaches of confidentiality caused by the patient/parent/legal guardian or any third party.
i. It is the patient/parent/legal guardian's responsibility to follow up with email and/or text messages and/or the scheduling of appointments if warranted.
j. Sports Medicine Consulting and its representatives are not responsible for any fees incurred as a result of any/all electronic transmissions.

3. Withdrawal of Consent: I understand that I may revoke this consent at any time by so advising Sports Medicine Consulting in writing. My revocation of consent will not affect my ability to obtain future healthcare nor will it cause the loss of any benefits to which I am entitled.
4. Client/Patient Acknowledgment and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or text messages as a form of communication between Sports Medicine Consulting staff and

me, and I consent to the conditions and instructions outlined in this document, as well as any other instructions that Sports Medicine Consulting may impose to communicate with me by email or text messages.

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Worker's Compensation Injury Form

Is the treatment that you (ie, the patient) are seeking related to a Worker's Compensation claim or are any medical bills to be reimbursed from a Worker's Compensation Settlement.

[ ] YES [ ] NO

Please Print and Sign Patient's Name

I am the parent/guardian of this patient _____

Date:_____