Print 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

Seivert Orthopedics & Sports Medicine, P.C.

Patient Information Packet

Please fill out the following packet in entirety by printing the packet and filling out by hand or by filling out the packet electronically.
Arrive 10 minutes early for your scheduled appointment along with a valid state driver's license and your insurance card.
If you are being seen for your shoulder, neck, or back, please bring a tank top. If you are being seen for a knee, low back, or hip, please bring a pair of loose fitting gym shorts. Please make sure all clothing is free of any metals in case an x-ray is needed.
All co-pays or balances are required at the time of service. Accepted forms of payment are cash and check.
If you have any questions about your appointment time, insurance benefits, or payment, please call our office at the number listed below.

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

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PATIENT REGISTATION FORM

Account #

Patient Name _____ Responsible Party's Name _____

Address _____ City, State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____ Sex ☐ Male ☐ Female

Birth Date _____ Age _____ Patient's Social Security # _____

Is this an Injury? ☐ Yes ☐ No Related to? ☐ Auto Accident ☐ Job Related ☐ Other

Explain _____

If Industrial, Reps Name and Phone # _____

Is Patient ☐ Single ☐ Married ☐ Other How were you Referred to Our Office? _____

Is Patient ☐ Employed ☐ Not Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

Responsible Party Social Security # _____ Relationship to Patient _____

Employer/School Name and Address _____ Occupation _____

Spouse or Nearest Relative Name/Address _____

What are You Being Seen for? _____ Date of Injury/Symptoms _____

Medication Allergies _____ Are You Pregnant? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Co. Name _____

Policy Holder's Name _____

Relationship to Patient _____

Employer _____

Policy # _____ Group # _____

Policy Holder's Sex ☐ Male ☐ Female

Policy Holders Date of Birth _____

Secondary Insurance Co. Name _____

Policy Holder's Name _____

Relationship to Patient _____

Employer _____

Policy # _____ Group # _____

Policy Holder's Sex ☐ Male ☐ Female

Policy Holders Date of Birth _____

I hereby authorize Seivert Orthopedics & Sports Medicine, P.C. to release any information required from my examination or treatment. I hereby authorize payment directly to Seivert Orthopedics & Sports Medicine, P.C. at 4611 E. Shea Blvd. Ste 200, Phoenix, AZ 85028 for all services I have received. I understand I am financially responsible for services not covered by my insurance carrier. I further agree to pay all finance charges, collection costs, attorney fees, and any other cost incurred to enforce my account.

Signed _____ Date _____

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PATIENT HISTORY AND PHYSICAL

Name _____ Date _____

Reason for today's office visit: _____

List any current medications taken on a regular basis: _____

List previous hospitalizations/surgeries: _____

Pre-Existing Conditions

	Patient	Family
Eyes, Ears Nose, Throat		
Glaucoma		
Cataracts		
Thyroid		
Heart		
Hypertension		
Lungs		
Asthma		
Emphysema		
Tuberculosis		
Gastrointestinal		
Ulcers		
Crohns		
Hernia		
Hepatitis		
Genitourinary		
Bladder		
Cancer		

	Patient	Family
Musculoskeletal		
Neck		
Back		
Joints		
Skin		
Eczema		
Neurological		
Epilepsy		
Migraines		
Psychiatric		
Depression		
Endocrine		
Diabetes		
Blood		
Lymphoma		
Allergy		
Food		
Medicine		

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OFFICE FINANCIAL POLICY

Seivert Orthopedics and Sports Medicine, P.C. prefers payment for patient care at the time of service. As a courtesy to you, we will bill the insurance company for you.

Workers' Compensation: If your claim is denied or not accepted, you will be responsible for all charges. If the claim is accepted, we will receive payment from the industrial insurance carrier.

Private Health Insurance: You will be responsible for all co-payments, co-insurance, and annual deductible. Insurance policies are agreements between the policy holder and the insurance company. Any discrepancy in your benefits is between you and your insurance company.

Automobile Insurance: Should the claim for physician payment be denied or suspended by the auto insurance carrier, we will bill your private health insurance. The patient assumes personal responsibility to pay for medical care in full.

Medical Lien: If a medical lien is in place as the result of an auto accident or personal injury case, the patient will remain financially liable to the physician for any and all medical services.

No insurance: Payment is due at the time services are rendered unless previous arrangements have been made.

Please Note: Any and all forms/paperwork from insurance companies and otherwise above and beyond your regular office visit will incur a change of $40 dollars per form billed directly to the patient.

Please note: Missed appointment charges will be incurred, with less than a 24 hour cancellation, at a rate of $60 per missed appointment billed directly to the patient.

If your insurance company does not remit payment within 30 days from the date of services, the balance will be due in full by you.

Patient	Date
Business Office Manager	Date

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NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

Patients Rights

Right to request your medical information: You have the right to look at your own medical records and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care.

Right to request amendment of medical information you believe is erroneous or incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record.

Right to get a list of certain disclosures of your medical information: You have the right to request a list of many of the disclosures we make of your medical information.

Right to request restrictions on how our office will use or disclose your medical information for treatment, payment, or health care operations: You have the right to ask us not to make uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the office. We are not required to agree to your request, but if we do agree, we will comply with that agreement.

Right to request confidential communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. (For example: you request us not to call your home or work or to communicate with you only by mail, or you can ask to speak to your healthcare provider in private outside the presence of other patients.)

Notice of Privacy Practices
How We Will Use and Disclose Your Medical Information:

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, medical equipment providers, medical facilities, and others involved in your care.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to patients. (For example, your health plan or insurance company may require to see parts of your medical records before allowing payment for your treatment.)

Required by Law: Federal, state, or local laws sometimes require us to disclose patient's medical information. For instance, we are required to give information to the Arizona Worker's Compensation Program for work related injuries.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report communicable diseases to the State of Arizona. We may also be required to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Judicial Proceedings: Our office may disclose medical information if ordered to so by a court or if we receive a subpoena or search warrant.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS. For these types of information, our office is required to get your permission before disclosing to others in many circumstances.

Other Uses and Disclosures: If our office wishes to use or disclose your medical information for a purpose that is not discussed in this notice, our office will seek your permission. If you give your permission to our office, you may take back your permission at any time by notifying our office in writing, unless we have already relied on your permission to use or disclose the information.

Patient's Signature	Date
Office Manager's Signature	Date