☐ NEW PATIENT ☐ UPDATE DR: _____

DATE: _____ PATIENT ACCT. #: _____

PATIENT'S LEGAL NAME:
(First) _____ (Middle) _____ (Last) _____ Sex: M F
Social Sec. #: _____ DOB: _____ Age: _____ Marital Status: M S W D
Address: _____ City, State and Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
E-Mail Address: _____
Religious Preference: _____
Primary Physician Name and Phone: _____

EMERGENCY CONTACT:
Name: _____ Phone#: _____ Relationship: _____

DATE OF INJURY: _____

RESPONSIBLE PARTY: (If the patient is a minor, person responsible for billing account)
Name: _____ Relationship to patient: _____ Sex: M F
Address: _____ DOB: _____
City, State and Zip: _____ Social Sec. #: _____
Phone #: _____ Employer: _____

PRIMARY INSURANCE:
Insurance Company: _____ Primary Insured's Name: _____
Insured's Group #: _____ Insured's ID #: _____
Insured's Phone #: _____ DOB: _____ Social Sec. #: _____

SECONDARY INSURANCE:
Insurance Company: _____ Primary Insured's Name: _____
Insured's Group #: _____ Insured's ID #: _____
Insured's Phone #: _____ DOB: _____ Social Sec. #: _____

PHARMACY NAME: _____
PHARMACY PHONE: _____

PLEASE READ: Some insurance companies will not pay your bill if you do not select one of their participating physicians. It is the patient's responsibility to determine if our physician participates in your insurance plan. Payment or copayment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney's fees. By signature below, the parent or guardian agrees that the jurisdiction and venue for said action shall be the county of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).
SIGNED (Patient or Guardian) _____ Date: _____

AUTHORIZATION AND ASSIGNMENT: I authorize Performance Sports Medicine Institute (PSMI) to release information regarding my treatment to my insurance co., to health care providers who have referred me to PSMI and to parties who are involved in my treatment if I have a work related injury. I also authorize my insurance benefits to be paid directly to PSMI or the individual physicians. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event PSMI is served with a subpoena for production of records, the undersigned authorizes PSMI to produce such records under a business records affidavit without the necessity of attendance at a deposition. This above authorization can only be withdrawn or revoked by written notification to PSMI.

SIGNED (Patient or Guardian) _____ Date: _____

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Patient Health Questionnaire for Dr. Paletta's Office:

Name:_____ Date: _____

Age:____ Date ofBirth:_____ Height:_____ Weight:_____ Gender☐M☐F

Referring Physician:_____ Primary Care Physician:

Reason for Today's visit? _____

When Did this problem begin? _____

Have you seen a doctor for this problem?☐N☐Y If yes whom did you see? _____

Have you had any tests for this problem?☐N☐Y If yes please list below.

	Date	Where tests were done	Results:
X-rays			
MRI			
CT Scan			
Bone Scan			
EMG			
Other			

What treatment(s) have you tried so far?

- ☐ Rest/Activity Modification
- ☐ Physical Therapy/Exercises
- ☐ Immobilization(cast, splint, sling)
- ☐ Braces/Orthotics
- ☐ Chiropractic
- ☐ Massage
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Pain Medication
- ☐ Anti-inflammatories
- ☐ Steroid/Cortisone Injection
- ☐ Tylenol

Previous Surgery for this problem:_____

_____

Medications you are currently taking for this problem?

_____

Do you have any of the following conditions or illnesses?

High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Asthma/Lung Disease ☐

Gastrointestinal/GI Diseases Stomach Ulcers ☐ Arthritis ☐ Kidney Disease ☐

Thyroid Disease ☐ Cancer: _____

Previous Surgery:

Procedure	Date	Hospital	Surgeon

Current Medications:

Drug Name	Dose

Allergies: _____

_____ **Are you**

currently having problems with any of the following?

Eyes/vision . .	☐	Ears/hearing	☐	Nose/smelling	☐	Throat/swallowing	☐
Lungs/breathing	☐	Shortness of breath	☐	Chest Pain	☐	Palpitations	☐
Indigestion.	☐	Urinary Problems	☐	Dizziness	☐	Fainting	☐
Seizures	☐	Fever/Chills	☐	Infections	☐	Bleeding disorders	☐
Ankle swelling	☐	Numbness/tingling	☐	Balance	☐	Weight loss/gain	☐

Other problems not listed above: _____

Family History:

Family Member	Alive or Dead	Age	Illness or Cause of Death
Grandmother (Mom's)			
Grandfather (Mom's)			
Grandmother (Dad's)			
Grandfather (Dad's)			
Mother			
Father			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Sister/Brother			

Social History:

Are you employed? ☐ Y ☐ N Occupation:_____ ☐ Student ☐ Retired

Marital Status: Single Married Divorced Widowed Children? N Y Number_____

Do you exercise? ☐ N ☐ Y How often?_____ What type?_____

Do you smoke? ☐ N ☐ Y Packs per day?_____ How many years?_____

Did you used to smoke? ☐ N ☐ Y If yes when did you quit?_____

Do you drink alcohol/beer/wine? ☐ N ☐ Y Daily 1-2 times per week 1-2 times per month

Do you use other drugs? ☐ N ☐ Y If yes, what type?_____

Is this a work Related injury? ☐ N ☐ Y Is there a lawsuit related to your injury? ☐ N ☐ Y

Patient Signature:_____

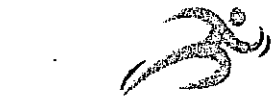
Parent or Guardian Signature (if patient < 18 yrs. old):_____

☐ By checking this box I affirm my intent to sign this form electronically by typing my name above

Physician Statement of Review: I have reviewed the above patient health history.

Physician Signature:_____

☐ By checking this box I affirm my intent to sign this form electronically by typing my name above



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NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Performance Sports Institute's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. Should our Notice of Privacy Practices change, we will provide you with a revised copy as provided in the Notice of Privacy Practices.

PRINT Patient's Name _____ Date _____

Signature (Patient/Guardian) _____ **PRINT Guardian's Name** _____

☐ By checking this box I affirm my intent to sign this form electronically by typing my name above.

FOR PSMI USE ONLY

Inability to Obtain Acknowledgement

If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

_____

_____

Signature of PSMI representative: _____

☐ By checking this box I affirm my intent to sign this form electronically by typing my name above.

Name of PSMI representative: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because other health-care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena,

discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Session Notes: I do keep "Session notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

   a. For my use in treating you.

   b. For my use in training or supervising associates to help them improve their clinical skills.

   c. For my use in defending myself in legal proceedings instituted by you.

   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

   e. Required by law and the use or disclosure is limited to the requirements of such law.

   f. Required by law for certain health oversight activities pertaining to the originator of the session notes.

   g. Required by a coroner who is performing duties authorized by law.

   h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a health care provider, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a health care provider, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on the date of signature.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

☐ By checking this box I affirm my intent to sign this form electronically by typing my name below.

Signature: _____ DATE: _____

PSMI | Performance Sports Medicine Institute

George A. Paletta Jr. M.D.

Authorization & Consent For Release of Information

This form allows Performance Sports Medicine Institute to release records from our office, discuss medical treatment and/or any billing issues with the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

School: _____ Trainer: Phone: _____

May we leave a voicemail message on your phone? ☐ Yes ☐ No

If Yes, Check all that apply: ☐ Cell ☐ Home ☐ Work

May we Text your Cell? ☐ Yes ☐ No

May we call your cell regarding billing issues? ☐ Yes ☐ No

Parent or guardian signature if a minor: _____

Signature: _____ Date: _____

☐ By checking this box I affirm my intent to sign this form electronically by typing my name above

333 S. Kirkwood * Suite 200 * Kirkwood * MO * 63122 * P # (314) 392-5045 * F # (866) 400-6144