# AHLFELD SPORTS MEDICINE INTAKE FORMS

- **Please print and fill out all forms completely and thoroughly**

- **Bring these forms along with Photo ID and Insurance cards to your initial visit**

- **Please bring a list of current medications including dosage**

- **Wear appropriate attire for examination**
  - **(ex: shorts or loose sweatpants for knee pain)**

# AHLFELD SPORTS MEDICINE

## PATIENT INFORMATION SECTION

NAME: ______________________ ______________________ ______________
Last First (legal) M.I.

ADDRESS: ______________________________________________
No. and Street City State Zip

HOME PHONE: ( )____________ WORK PHONE: ( ) ____________ EXT: ______

CELL PHONE: ( )____________

DATE OF BIRTH: ________ SOCIAL SECURITY #__________ MARITAL STATUS______ SEX ______

EMPLOYER: ______________________ YOUR OCCUPATION: ______________________

SPOUSE'S NAME: __________ DATE OF BIRTH: ________ SOCIAL SECURITY:__________

SPOUSE'S EMPLOYER: ______________ WORK PHONE: ( ) ____________ EXT:______

FAMILY PHYSICIAN NAME & ADDRESS: ______________________________

WHO WERE YOU REFERRED BY? ______________________________

## STUDENT INFORMATION SECTION

SCHOOL NAME: ______________________ SPORTS YOU ARE INVOLVED WITH: ______________

COACH'S NAME: ______________________ TRAINER'S NAME: ______________________

## REPONSIBLE PARTY SECTION (PARENT OR LEGAL GUARDIAN BRINGING MINOR CHILD UNDER AGE 18)

NAME: ______________________________ DATE OF BIRTH: ______________
Last First (legal) M.I.

ADDRESS: ______________________________ SOCIAL SECURITY#__________
No. and Street City State Zip

HOME PHONE: ( ) ________WORK PHONE: ( )________ RELATIONSHIP TO PATIENT: ______

## INSURANCE INFORMATION SECTION

PLEASE PRESENT YOUR CARD & PHOTO I.D. TO RECEPTIONIST TO COPY

INSURANCE COMPANY NAME: ______________________ INSURED'S NAME: ______________

INSURED'S ADDRESS: ______________________________________________
No. and Street City State Zip

INSURED'S PHONE: ( ) ______________________ INSURED'S WORK PHONE:____________

INSURED'S DATE OF BIRTH: ________________ INSURED'S SOCIAL SECURITY#______________

## CONSENT AND ASSIGNMENT

I hereby authorize direct payment of medical benefits to Steven K. Ahlfeld, M.D. for services rendered to myself or my dependent (s). I also authorize Steven K. Ahlfeld, M.D. to release any medical or incidental information that may be necessary for medical care to my Insurance Carrier. I also hereby authorize and consent to the giving of all treatments, examinations, medications and any procedures deemed necessary by Steven K. Ahlfeld, M.D. that may be considered necessary or advisable for diagnosis or treatment.

Responsible Party Name: ______________________________________________

Please print

Signature: ______________________________ Date: ____________________

## FINANCIAL RESPONSIBILITY

I understand that payment for medical services rendered is to be paid at the time of service for all non-contracted insurance plans. These include but are not limited to traditional insurance plans, auto accident liability, non-authorized Worker's Compensations claims as well as non-insured's.

If I am covered under an insurance plan that Dr. Steven K. Ahlfeld has contract with, a claim will be filed on my behalf and I will be responsible for any deductible, co-pay amounts and/or any non-covered services which could include but is not limited to any services that my insurance company deems not medically necessary. I agree that any up front office co-pays will be paid at that time of service. Furthermore, if I am covered under an insurance plan that requires prior authorization before seeing a specialist, I have obtained this prior authorization. If this has not been obtained, I understand that I will be responsible for payment of all fees at the time of service.

I also understand that if I have not met my deductible for any calendar year that I will be responsible to pay any fees up to my policy amount at the time of service.

In cases of Divorce, it is the FULL RESPONSIBILITY of the parent who brings their child in and signs for authorization of treatment for full payment of services.

In the event that any unpaid balance is referred for collections, I agree to be responsible for any and all collections fees, attorney fees and court costs if necessary.

REPSONSIBLE PARTY NAME: ______________________________________________

Please Print

RESPONSIBLE PARTY SIGNATURE: ______________________________DATE:______________

**Ahlfeld Sports Medicine Orthopedic Center** **Practitioner's Initials**________
**History and Physical Form**

## PATIENT HISTORY

Please PRINT and fill out completely.

Name:________________________________________________________ Today's Date:______________

Age:__________ Height:______________________ Weight:______________ Hand Dominance: ☐ Left ☐ Right

**HISTORY OF INJURY**

What current problem (chief complaint) are we seeing you for today?________________________________
Did the problem result from a specific injury? ☐Yes ☐ No **Injury/AccidentDate:**________________
Did your problems begin following: ☐Work injury? ☐ Motor Vehicle Accident? **What State?**__________
How did you get injured?________________________________________________________________
If neither, how long have you had the condition?__________________________________________
Please rate your pain on a scale of 1 to 10 (10 being the most painful):__________________________
Is the pain: ☐ Constant ☐ Occasional ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing
What symptoms are you experiencing? ☐Locking☐Catching☐Giving Away☐Popping☐Grinding☐Other
What, if anything, makes your symptoms better?__________________________________________
What, if anything, makes your symptoms worse?__________________________________________
Have you seen another physician for this injury? ☐ Yes ☐ No
If yes, who?______________________________________________________________________
What treatments have you tried? ☐ Nothing ☐ Physical Therapy ☐ Exercise ☐ Acupuncture
☐Chiropractic ☐ Injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)
☐Medications______________________________________________________________________
☐Other___________________________________________________________________________
Have you had any of the following tests? Test Date (month/year) What facility? (clinic/hospital)
☐ X-rays__________________________________________________________________________

☐ MRI scan________________________________________________________________________

☐ CT scan_________________________________________________________________________

☐ EMG/NCV_______________________________________________________________________

☐ Discogram_______________________________________________________________________

☐ EKG____________________________________________________________________________

☐ Blood Tests______________________________________________________________________

☐ Other___________________________________________________________________________

**Regular Exercise:** ☐ Yes ☐ No Type of exercise and activity you enjoy:______________________

__________________________________________________________________________________

__________________________________________________________________________________

**PHARMACY ADDRESS & PHONE NUMBER**

__________________________________________________________________________________

**Health History – page 2**
**Patient Name** ______________________________

## PAST SURGICAL HISTORY

Please check any previous surgical procedures, list the date and describe surgery:
☐ Appendectomy ☐ Hernia Repair ☐ Arthroscopy Lower Extremity ☐ Upper Extremity
☐ Spine / Back Surgery ☐ Heart Surgery ☐ Total Joint Replacement ☐ Fracture Repair
☐ Other: ______________________________

______________________________

## SOCIAL HISTORY

Special Diet: ☐ Yes ☐ No Any restrictions? ______________________________
Tobacco Use: ☐ Yes ☐ No Type: ______________________________
Alcohol Use: ☐ Yes ☐ No Frequency: ______________________________
Drug Use: ☐ Yes ☐ No Frequency: ______________________________
Caffeine Use: ☐ Yes ☐ No Frequency: ______________________________

## ALLERGIES

Are you allergic to any medication? **Sulfa** ☐ Yes ☐ No **Latex** ☐ Yes ☐ No ☐ No known drug allergies
Please list all medications that you are allergic to: ______________________________

______________________________

## MEDICAL HISTORY

Please check current or previous medical conditions:
☐ Anemia ☐ Depression ☐ Hepatitis A or B ☐ Osteoporosis
☐ Arthritis ☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Asthma ☐ Emphysema ☐ HIV ☐ Stroke / Seizures
☐Blood Clots ☐ Heart Disease ☐ Irregular Heartbeat ☐ Thyroid
☐ Cancer ☐ Liver Disease ☐ Chemical Dependency and/or Alcoholism
☐ Other______________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? ______________________________

## MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include vitamin, mineral and herb supplements.
**Medication Dosage Frequency**

______________________________
______________________________
______________________________
______________________________
______________________________

## GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? ☐ Yes ☐ No If yes, when? ______________________________
Do you have a history of GI, stomach bleed? ☐ Yes ☐ No If yes, when? ______________________________
Do you take any medications for your stomach? ( Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc., dosage and frequency) ______________________________
Have you ever taken anti-inflammatory medicine for a period greater than 30 days? ( Please include over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex, and Vioxx. List all you have tried).

______________________________

**FAMILY HISTORY**

Please check family history conditions:

☐ Blood clots ☐ Diabetes ☐ Hypertension ☐ Rheumatoid Arthritis
☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke / Seizures

Please describe any immediate family history of medical problems: ______________________________

______________________________________________________________________

______________________________________________________________________

**REVIEW OF SYSTEMS**

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems please check in the negative box.

1. CONSTITUTIONAL GENERAL ☐ None ☐ Weight loss ☐ Insomnia ☐ Chronic Fatigue
☐ Other ______________________________

2. EYES ☐ None ☐ Vision change ☐ Glasses/Contacts ☐ Cataracts ☐ Glaucoma ☐ Pain ☐ Discharge
☐ Other ______________________________

3. EARS, NOSE, THROAT ☐ None ☐ Loss of hearing ☐ Seasonal Allergies ☐ Sinus Pain ☐ Ringing ☐ Nose Bleeds
☐ Other ______________________________

4. CARDIOVASCULAR ☐ None ☐ Chest Pain ☐ Edema ☐ Hypertension ☐ Palpitations ☐ Fainting ☐ High cholesterol
☐ Other ______________________________

5. RESPIRATORY ☐ None ☐ Asthma ☐ Wheezing ☐ Frequent Cough
☐ Other ______________________________

6. GASTROINTESTINAL ☐ None ☐ Heartburn ☐ Indigestion ☐ Acid Reflux ☐ Ulcer Problems ☐ Vomiting
☐ Abdominal Pain ☐ Peptic Ulcer ☐ GI, Stomach Bleed ☐ Nausea
☐Other ______________________________

7. MUSCLUOSKELETAL ☐ None ☐ Arthritis ☐ Muscle Weakness ☐ Joint Pain ☐ Back Pain
☐ Other ______________________________

8. SKIN ☐ None ☐ Rash ☐ Ulcers ☐ Scars
☐ Other ______________________________

9. NEUROLOGICAL ☐ None ☐ Headaches ☐ Seizures ☐ Numbness ☐ Dizziness
☐ Other ______________________________

10. PSYCHIATRIC ☐None ☐ Depression ☐ Crying ☐ Anxiety ☐ Mood Swing
☐ Other ______________________________

11. ENDOCRINE ☐ None ☐ Diabetes ☐ Hypothyroid ☐ Hyperthyroid ☐ Hot Flashes
☐ Other ______________________________

12. HEMATOLOGY ☐ None ☐ Easy Bruising ☐ Bleeding ☐ Anemia
☐ Other ______________________________

13. GENITOURINARY ☐ None ☐ Frequency ☐ Hesitancy ☐Flank Pain ☐ Painful Urination ☐ Blood in Urine
☐ Other ______________________________

Signature: ______________________________ Date: ______________

Print Name: ______________________________

# HIPPA NOTICE OF PRIVACY PRACTICES

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**Steven K. Ahlfeld, M.D.**
**9302 N. Meridian Street, Suite 110**
**Indianapolis, IN 46260**
**(317) 575-6515**

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

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## 1. Uses and Disclosures of Protected Health Information

**Uses and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-on sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements. Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organs Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**
Following is a statement of your rights with respect to your protected health information.

**Your have the right to inspect and copy your protected health information.** Under federal law, however, your may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **JANUARY 1, 2011.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:**

**Print Name**_________________________ **Signature**___________________________________ **Date**___________

IDENTITY THEFT PREVENTION "RED FLAG COMPLIANCE" POLICY:

It is the policy of Steven K. Ahlfeld, M.D. P.C., to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how Steven K. Ahlfeld, M.D. P.C. will (1) identify, (2) detect and (3) respond to "red flags".

It is the policy of Steven K. Ahlfeld, M.D. P.C. that this identity theft prevention and detection and "Red Flags Rule" compliance program is approved by Steven K. Ahlfeld as of January 1, 2013 and that the policy is reviewed and approved annually.

It is the policy of Steven K. Ahlfeld, M.D. P.C. that pursuant to the existing HIPPA Security Rule, appropriate physical, administrative and technical safeguards will be in place to reasonably safeguard protected health information and sensitive information related to the patient identity from intentional or unintentional use or disclosure.

It is the policy of Steven K. Ahlfeld, M.D. P.C. that all members of our workforce have been trained by January 1, 2013 compliance date on the policies and procedures governing compliance with the "Red Flags Rule". It is also the policy of Steven K. Ahlfeld, M.D. P.C. that new members of our workforce receive training on these matters within a reasonable time period after they have joined our workforce. It is the policy of Steven K. Ahlfeld, M.D. P.C. to provide training should any policy or procedure related to the "Red Flags Rule" change. This training will be provided within a reasonable time period. Furthermore, it is the policy of Steven K. Ahlfeld, M.D. P.C. that training will be documented, indicating participants, date and subject matter.

PATIENT SIGNATURE______________________________________

DATE:__________________________________________________

PRINTED NAME:__________________________________________

WITNESS:_______________________________________________

DATE:__________________________________________________