Christopher R. Rothrock, M.D.
phone: (314) 821-4423
fax: (314) 821-7706
web: www.stlsportshealth.com

PATIENT INFORMATION

Please complete and/or verify all information and make changes as necessary.

Today's Date:	**Is this injury work-related?** YES NO		

Patient Name (First-Middle-Last)	**Date of Birth**	**Age**	**Gender** M F O	**Marital Status** M S D W

Home Phone No.	**Cell Phone No.**	**Patient Social Security No.**	**E-mail Address**

Address Street #	**City/State/ZIP**	**Employment Status** Employed Unemployed Retired Student

Name of Employer/School	**Occupation**	**Employer Address (Street-City-State-ZIP)**	**Employer Phone No.**

Emergency Contact	**Relationship**	**Phone No.**	**Best # To Reach You During the Day** Home Cell Other (Pls. specify)

GUARANTOR INFORMATION/ INSURANCE INFORMATION

Name of person who is financially responsible for this patient?	**Relation to Patient**	**Phone No.**	**Date of Birth**

Primary Insurance Company Name	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**
Secondary Insurance Company Name	**Subscriber Name**	**Date of Birth**	**Relationship to Patient**

LEGAL GUARDIAN (IF MINOR)

Legal Guardian Name (First-Middle-Last)	**Address Street #**	**City/State/ZIP**	**Phone No.**

MISCELLANEOUS (Please Complete All Entries)

Name of Primary Care Physician	**Phone Number**

How did you hear about our practice? Physician's office Work Comp Family & Friends Website Facebook Other: _______________

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

I hereby assign payment of authorized Medicare, Medicaid and/or any Insurance Carrier listed to include major medical benefits to which I am entitled, to be made on my behalf to St. Louis Sports Health, LLC for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, and/or any Insurance Carrier listed, any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

______________________________ ______________________________ ______________________________

Patient (Legal Guardian)'s Signature **Patient (Legal Guardian)'s Printed Name** **Date**

MEDICARE: St. Louis Sports Health, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
INSURANCE: I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that all office co-pays are due at time of service. In addition, I agree to pay any additional charges related to the cost of collection including but not limited to collection agency fees, reasonable attorney fees and court costs, in the event that I would fail to pay my bill.

______________________________ ______________________________ ______________________________

Guarantor's Signature **Guarantor's Printed Name** **Date**

Medical Information Form
Christopher R. Rothrock, MD

Name: ______________________ **DOB:** ________________ **Date:** ______________

Who recommended you to our office? ______________________________
Who is your Primary Care Physician? ______________________________

PRESENTING PROBLEM:

What is bothering you? ______________________________
When did your current problem start? ______________________________
Were you injured at work? Yes ❑ No ❑
Is there a possibility you are pregnant? Yes ❑ No ❑

ALLERGIES:

Have you ever experienced an allergic reaction to the following?
Latex Yes ❑ No ❑ Adhesives Yes ❑ No ❑ Iodine/Betadine Yes ❑ No ❑
Please list any drug allergies that you have.

____
____

FAMILY HISTORY:

Do any of the following conditions run in your family?

Arthritis	Yes ❑	No ❑	Relationship: ______________
Cancer	Yes ❑	No ❑	Relationship: ______________
Diabetes	Yes ❑	No ❑	Relationship: ______________
Heart Problems	Yes ❑	No ❑	Relationship: ______________
Lung Problems	Yes ❑	No ❑	Relationship: ______________

PAST MEDICAL HISTORY:

Have you ever tested positive for any of the following conditions?

Hepatitis	Yes ❑	No ❑	Tuberculosis	Yes ❑	No ❑	HIV	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑	Blood Clot	Yes ❑	No ❑	Staph Infection	Yes ❑	No ❑

If you have ever been diagnosed with any of the following conditions, please check.

❑ High Blood Pressure	❑ High Cholesterol	❑ Heart Disease	❑ Thyroid Problems
❑ Depression	❑ Emphysema	❑ Asthma	❑ Kidney Stones
❑ Bleeding Disorder	❑ Ulcer	❑ Seizures	❑ Nerve / Brain Injury
❑ Stroke	❑ Glaucoma	❑ Cataracts	❑ Cancer of ______________
❑ Rheumatoid Arthritis	❑ Immunological Disorder	❑ Other:	______________

PAST SURGICAL HISTORY:

PAST DIFFICULTY WITH ANESTHESIA:

____

Name: ______________________ **DOB:** ____________________ **Date:** ____________________

SOCIAL HISTORY:

Do you smoke?	Yes ❑	No ❑	***If yes, how much?***	____________
Do you drink alcohol?	Yes ❑	No ❑	***If yes, how much?***	____________
What is your marital status?	Single ❑	Married ❑	Divorced ❑	Widowed ❑
What is your race/ethnicity?	____________			

MEDICATIONS:

Please list any medications you are currently taking.

REVIEW OF SYSTEMS:

Please check any of the following symptoms that you are currently experiencing.

CONSTITUTIONAL	Yes	No
Fever	☐	☐
Chills	☐	☐
Fatigue	☐	☐

HEENT	Yes	No
Headache	☐	☐
Vision Changes	☐	☐

HEMATOLOGY	Yes	No
Bruise Easily	☐	☐

CARDIOVASCULAR	Yes	No
Shortness of Breath	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐

MUSCULOSKELETAL	Yes	No
Joint Pain	☐	☐
Joint Swelling	☐	☐
Calf Pain	☐	☐

GASTROINTESTINAL	Yes	No
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bleeding	☐	☐

PSYCHIATRIC	Yes	No
Depression	☐	☐
Anxiety	☐	☐

IMMUNOLOGY	Yes	No
Latex Allergy	☐	☐
Seasonal Allergies	☐	☐

RESPIRATORY	Yes	No
Sleep Apnea	☐	☐

HEIGHT: ____________ **WEIGHT:** ____________

Patient or Guardian Signature: ______________________ **Date:** ____________________

***__BELOW FOR OFFICE USE ONLY__ ***

UPDATE	**PATIENT SIGNATURE**	**PHYSICIAN INITIALS**

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Acknowledgement of Receipt of Notice of Privacy Practices
&
Authorization to Release Information to Specified Family Members and Close Friends

PATIENT NAME: ____________________ **D.O.B.:** ______________________________

Acknowledgement of Receipt

I have received or had access to a copy of the Notice of Privacy Practices for **St. Louis Sports Health, LLC.**

______________________________ ______________________________
Signature of Patient/Guardian/Parent Date

____
Relationship of Patient Representative to Patient

Authorization to Release Health Information to Family Members & Close Friends

I authorize **St. Louis Sports Health, LLC** to disclose health information to the following family members and/or close friends to the extent necessary to help with my healthcare.

Name	D.O.B. and Relationship to the Patient
1.	
2.	
3.	

______________________________ ______________________________
Signature of Patient/Guardian/Parent Date

____
Relationship of Patient Representative to Patient

Authorization to Leave a Message

I authorize **St. Louis Sports Health, LLC** to leave reminders and call back information on the following answer machine(s).

Home:_______________ Cell:____________________ Office:__________________ None:__________________

______________________________ ______________________________
Signature of Patient/Guardian/Parent Date

Inability to Obtain Acknowledgement of Receipt

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _______________. The acknowledgement was not obtained because:

- ❑ The parent/guardian/patient declined to sign the acknowledgement
- ❑ Other____

______________________________ ______________________________
Signature of Staff Member Date

ST. LOUIS SPORTS HEALTH, LLC

Patient Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, our financial policy is in writing. For your convenience, we have answered some commonly asked questions below. If you have further questions, please contact our billing department at (314) 432-2580.

What insurances do you accept?
We accept many insurance plans. The plans in which we participate are subject to change. It is your responsibility to verify we are a provider for your plan and to verify benefits. Please bring your insurance card(s) with you to every visit. For billing purposes, it is important that you notify us immediately when your insurance changes.

What if I need to see the doctor for a work-related injury?
If your injury is due to an accident in your work place, please contact your employer and inform them of your injury. We will need to receive authorization from your employer's insurance carrier before we can schedule an appointment for you. Failure to properly report an injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

What do I need to bring with me to my appointment?
Please bring your insurance card with you to every appointment. We also require photo identification.

Do co-pays need to be paid at the time of my appointment?
Yes. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. You are expected to make your co-pay upon arrival for your appointment. If unable to make your co-payment, your appointment will be rescheduled.

How am I to pay my portion after you bill the insurance?
You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Once we receive the Explanation of Benefits from your insurance company, we will bill you for the balance that you owe. That amount is due upon receipt of the statement.

How may I pay?
We accept payment by cash, check or credit card (VISA, Mastercard and Discover Card).

What is your policy regarding missed appointments?
If you are unable to keep your scheduled appointment, please contact our office within 24 hours to reschedule your appointment. This will enable us time to use your slot for another patient. Patients who do not show up for an appointment and do not call to cancel have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patient's insurance contract, we reserve the right to charge for missed appointments.

What if my child needs to see the physician?
A parent or legal guardian must accompany all patients who are minors on the patient's first visit, and must sign the financial statement for the patient, accepting responsibility for the account.

What if my check bounces?
If a check is returned for insufficient funds or if payment has been stopped, you will be charged a $25 fee in addition to the amount of the check. If you have a second check returned, you may be asked to pay by cash, money order or cashier's check or credit card.

What if I do not pay my bill?
Accounts that are repeatedly ignored may be sent to collections. If this happens, your credit may be adversely affected and you will be dismissed from the practice.

Are there other fees I may anticipate?
There will be additional charges for the completion of medical or disability forms or for copies of medical records or x-rays. These charges may vary. Payment and a signed release form must be received before the forms and/or records will be released. Please allow 7-10 business days for disability forms to be completed and up to 30 days for medical records requests to be processed. If you would like them mailed to you or your insurance company, there will additional fees for the cost of postage.

Acknowledgement

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-pays and deductibles, are my responsibility. I authorize insurance benefits be paid directly to St. Louis Sports Health, LLC, and I authorize them to release any pertinent medical information to facilitate payment of a claim.
I have received a copy of this policy.

Date | Signature of Responsible Party | Printed Name | Patient Name (if different)