ENHANCED DIRECT SPECIALTY CARE

DR. ADAM REDLICH & DR. ADAM THOMPSON

THANK YOU FOR CHOOSING US AS YOUR PROVIDER!
WE ARE COMMITTED TO PROVIDING YOU WITH QUALITY AND AFFORDABLE HEALTHCARE.

Insurance: We accept payment from most insurance plans, and participate with Medicare and VA (Veterans). We will check your out of network eligibility and benefits, we encourage you to do the same. Payment for your portion is due at time of visit. We offer easy payment arrangements, if financial hardship exist and management approval is given.

Copay and Deductibles: All payments towards co-payments, co-insurance and deductibles are due at time of service. We will bill your private insurance as an out of network provider. If you have met $100+ of your out of network deductible we will collect 70% of the billed amount at the time of service.

Proof of Insurance: We will take a copy of your driver's license or government ID and valid insurance card.

Claims submission *if applicable: Your insurance may supply you with certain information or payments, such as a check. It is your responsibility to provide this information or payments to our office within 14 days, otherwise collection and or legal action will be initiated with rare exceptions

Nonpayment: Partial payments are not accepted. We refer all past due accounts to a collection agency service.

Missed appointment: There is a $50 charge for no show, same day or late cancellation (less than 24 hours)

I HEARBY AGREE TO BE RESPONSIBLE FOR CHARGES COVERING ALL SERVICES RENDERED BY A+ATHLETE - SPORTS MEDICINE. I SHALL ALSO BE RESPONSIBLE FOR ALL COLLECTION FEES AND OR ATTORNEY FEES REQUIRED TO COLLECT PAST DUE ACCOUNTS. I ACKNOWLEDGE AND UNDERSTAND THAT I AND ANY GUARANTOR SIGNING ON MY BEHALF ARE PERSONALLY RESPONSIBLE FOR ALL CHARGES. I AUTHORIZE, A+ATHLETE - SPORTS MEDICINE, LLC, OR ITS AGENTS TO CONTACT ME IN ORDER TO COLLECT ANY PAST BALANCES. IT IS MY RESPONSIBILITY TO PAY FOR ALL SERVICES RENDERED.

Signature:_____ Date:_____

38A ROBBINSVILLE - ALLENTOWN RD. ROBBINSVILLE, NJ 609-223-2286
1944 CORLIES AVE. RT-33 #202 NEPTUNE, NJ 732-359-5420

NAME_____ DATE OF BIRTH___/___/____
SS#_____
ADDRESS_____CITY_____STATE____
ZIP_____ PHONE: _____
EMAIL_____
EMPLOYER_____ WORK#_____

PHARMACY/LOCATION: _____PHONE_____
REFERRING PHYSICIAN/PROVIDER_____
PHONE_____ FAX_____
PRIMARY CARE PHYSICIAN/PROVIDER_____
PHONE FAX

EMERGENCY CONTACT:
NAME_____PHONE_____
RELATION_____
NAME_____PHONE_____
RELATION_____

INSURANCE INFORMATION:
PRIMARY INSURANCE NAME_____
ID#_____ GROUP#_____
SUBSCRIBER NAME: _____RELATIONSHIP TO PATIENT_____
SUBSCRIBER DATE OF BIRTH _____
SECONDARY INSURANCE NAME_____
ID# GROUP#
SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT_____
SUBSCRIBER DATE OF BIRTH _____

MOTOR VEHICLE ACCIDENT:
DATE OF ACCIDENT: _____
CLAIM# _____ AUTO INSURANCE NAME _____
POLICY SUBSCRIBER: _____ POLICY#_____
ADJUSTOR_____
WORKMANS COMP:
DATE OF ACCIDENT: _____ CLAIM# _____
INSURANCE COMPANY _____ EMPLOYER_____

ASSIGNMENT OF RELEASE OF INFORMATION STATEMENT - I CERTIFY THAT THE INFORMATION GIVEN BY ME IS CORRECT. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATED TO MY MEDICAL CARE, AS REQUESTED BY GOVERNMENT AGENCIES AND/OR INSURANCE CARRIERS. I HEREBY ASSIGN BENEFITS TO MY PHYSICIAN AND UNDERSTAND THAT IN THE ABSENCE OF ACCEPTED INSURANCE COVERAGE, I/LEGAL GUARDIAN AM RESPONSIBLE FOR FULL PAYMENT OF SERVICES RENDERED. MEDICARE PATIENTS - I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THE TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I UNDERSTAND THAT I AM RESPONSIBLE FOR INSURANCE DEDUCTIBLES ON ALL SERVICES. 20% COINSURANCE. WHEN MEDICARE IS DEEMED THE SECONDARY INSURANCE, I WILL FOLLOW PAYMENT TERMS UNDER MY PHYSICIAN'S POLICIES.
PATIENT OR GUARDIAN'S SIGNATURE _____
DATE___/____/_____

Name:_____ Date of Birth:_____ Age: _____

How did you hear about us? _____ Today's Date:_____

Type of sport / exercise / work: _____

Hand Dominance: ☐Right ☐Left ☐Ambidextrous

Reason for today's visit: _____

When did this problem start?: _____

How did this problem start (what happened)?: _____

_____

_____

_____

Since this problem started is it: ☐Better ☐Worse ☐Same

What best describes your pain? ☐ Sharp ☐Dull ☐ Aching ☐ Throbbing ☐ Electric

Are there any other associated symptoms? ☐Numbness ☐Tingling ☐Weakness ☐Swelling

What actions or activities bring your symptoms on?_____

_____

Rate your pain level from 0-10 (0= none / 10= most severe):

Current: ____/10 Best: ____/10 Worst: ____/10

How long does it last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Constant

Does your pain radiate/travel anywhere? _____

What makes your pain worse? _____

_____

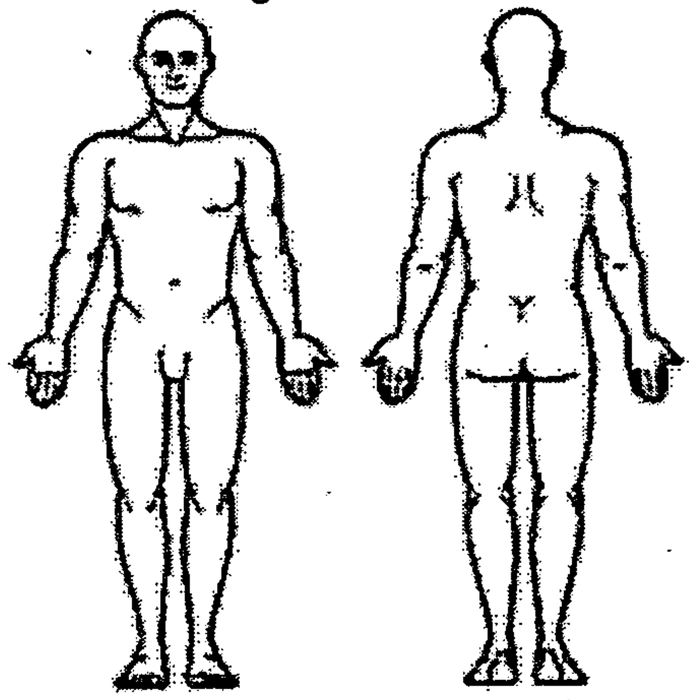
What makes your pain better?_____

_____

Have you had something like this before? _____

_____

Where is your pain located?
(Mark the diagram below with an X)



Have you had any care for this problem prior to today's visit? ☐ Yes ☐ No

Other healthcare providers (doctors, physical therapist, school athletic trainer, etc.): _____

_____

Diagnostic testing (ex. MRI, x-ray, EMG, etc.): _____

Medications (over the counter or prescribed) and/or treatments tried so far: _____

_____

Past Medical History:

- ☐ Migraines/Headaches
- ☐ Eye Problems
- ☐ Hearing deficit
- ☐ Asthma
- ☐ GERD / Reflux / Ulcer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Other Bone/Joint Condition
- ☐ Rheumatologic/Autoimmune Disorder
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Immunodeficiency
- ☐ Skin Condition
- ☐ Circulatory Disorder
- ☐ Other: _____

Please list any medications/supplements that you are taking below:

_____

_____

_____

_____

_____

Please list any allergies you have (include foods, medications, etc.):

_____

_____

_____

_____

_____

Please list any surgeries you've had with the approximate dates:

_____

_____

_____

_____

_____

Please list past hospitalizations with approximate dates and reason:

_____

_____

_____

_____

_____

Medical problems that run in your family:

- ☐ Arthritis
- ☐ Asthma
- ☐ Rheumatological conditions
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Other: _____

_____

_____

Marital Status: ☐ Married ☐ Single

Occupation/Company: _____

Exercise/Activity Level: ☐ None ☐ Mild ☐ Moderate ☐ Vigorous

Average days of moderate to vigorous exercise per week: _____

Average minutes of exercise per session: _____

Smoking Status: ☐ Non-smoker ☐ Smoker

Packer per day: _____ Years: _____

Review of Systems

General:
- ☐ Change in appetite
- ☐ Chills
- ☐ Fever
- ☐ Unexplained weight loss/gain

Allergy:
- ☐ Itching
- ☐ Hives

Eyes:
- ☐ Blurred vision
- ☐ Decreased vision

Ear/Nose/Throat:
- ☐ Decreased Hearing
- ☐ Runny Nose
- ☐ Sore throat

Endocrine:
- ☐ Feel too hot
- ☐ Feel to cold

Respiratory:
- ☐ Cough
- ☐ Shortness of breath

Cardiovascular:
- ☐ Chest pain
- ☐ Difficulty on exertion
- ☐ Irregular heartbeat / palpitations

Gastrointestinal
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Rectal bleeding

Hematology:
- ☐ Easy bruising
- ☐ Prolonged bleeding

Genitourinary:
- ☐ Change in urination
- ☐ Genital discharge/bleeding

Musculoskeletal:
- ☐ Other joint pains
- ☐ Other joint swelling

Vascular:
- ☐ Overly cold extremities

Skin:
- ☐ Rash

Neurologic:
- ☐ Headache
- ☐ Seizures

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Mental / physical abuse
- ☐ Learning Disability

Other:

_____

_____

_____

_____

HIPAA NOTICE OF PRIVACY PRACTICES

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 PRACTICES 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 CONDITION AND RELATED HEALTH CARE SERVICES.

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, 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 HEATH 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, EMPLOYEE REVIEW, TRAINING OF MEDICAL STUDENTS, LICENSING FUNDRAISING, 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-IN 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, AND INFORM YOU ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

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, ORGAN DONATION, RESEARCH, CRIMINAL ACTIVITY, MILITARY ACTIVITY AND NATIONAL SECURITY, WORKERS' COMPENSATION, INMATES, AND OTHER REQUIRED USES AND DISCLOSURES. UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOU UPON YOUR REQUEST. UNDER THE LAW, WE MUST ALSO DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN REQUIRED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INVESTIGATE OR DETERMINE OUR COMPLIANCE WITH THE REQUIREMENTS UNDER 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 THE 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 THE FOLLOWING ARE STATEMENTS OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION (FEES MAY APPLY) - UNDER FEDERAL LAW, HOWEVER, YOU MAY NOT INSPECT OR COPY THE FOLLOWING RECORDS: PSYCHOTHERAPY NOTES, INFORMATION COMPILED IN REASONABLE ANTICIPATION OF, OR USED IN, A CIVIL, CRIMINAL, OR ADMINISTRATIVE ACTION OR PROCEEDING. PROTECTED HEALTH INFORMATION RESTRICTED BY LAW, INFORMATION THAT IS RELATED TO MEDICAL RESEARCH IN WHICH YOU HAVE AGREED TO PARTICIPATE, INFORMATION WHOSE DISCLOSURE MAY RESULT IN HARM OR INJURY TO YOU OR TO ANOTHER PERSON, OR INFORMATION THAT WAS OBTAINED UNDER A PROMISE OF CONFIDENTIALITY. 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 AND BY LAW WE MUST COMPLY WHEN THE PROTECTED HEALTH INFORMATION PERTAINS SOLELY TO A HEALTH CARE ITEM OR SERVICE FOR WHICH THE HEATH CARE PROVIDER INVOLVED HAS BEEN PAID OUT OF POCKET IN FULL. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PROTECTED HEATH 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 THE SPECIFIC RESTRICTION REQUESTED AND TO WHOM YOU WANT THE RESTRICTION TO APPLY. BY LAW, YOU MAY NOT REQUEST THAT WE RESTRICT THE DISCLOSURE OF YOUR PHI FOR TREATMENT PURPOSES. YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS - YOU HAVE THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION 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 HAVE THE RIGHT TO REQUEST AN AMENDMENT TO 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 - YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF ALL DISCLOSURES EXCEPT FOR DISCLOSURES: PURSUANT TO AN AUTHORIZATION, FOR PURPOSES OF TREATMENT, PAYMENT, HEALTHCARE OPERATIONS; REQUIRED BY LAW, THAT OCCURRED PRIOR TO APRIL 14, 2003, OR SIX YEARS PRIOR TO THE DATE OF THIS REQUEST. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US EVEN IF YOU HAVE AGREED TO RECEIVE THE NOTICE ELECTRONICALLY. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AND WE WILL NOTIFY YOU OF SUCH CHANGES ON THE FOLLOWING APPOINTMENT. WE WILL ALSO MAKE AVAILABLE COPIES OF OUR NEW NOTICE IF YOU WISH TO OBTAIN ONE.

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 COMPLIANCE OFFICER OF YOUR COMPLAINT. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT. 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. WE ARE ALSO REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE CURRENTLY IN EFFECT. IF YOU HAVE ANY QUESTIONS IN REFERENCE TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPA4 COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMBER. PLEASE SIGN THE ACCOMPANYING "ACKNOWLEDGMENT" FORM. PLEASE NOTE THAT BY SIGNING THE ACKNOWLEDGMENT FORM YOU ARE ONLY ACKNOWLEDGING THAT YOU HAVE RECEIVED OR BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

ATHLETE
Sports Medicine

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILIT ACT (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I ACKNOWLEDGE THAT I HAVE RECEIVED OR HAVE BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF YOUR NOTICE OF PRIVACY PRACTICES. I ALSO UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES AND THAT I MAY CONTACT THE PRACTICE AT ANY TIME TO OBTAIN A CURREN' COPY OF THE NOTICE OF PRIVACY PRACTICES.

PATIENT NAME OR LEGAL GUARDIAN (PRINT) _____
DATE___/____/_____ SIGNATURE_____

I AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PHYSICIAN(S) AND/OR FACILITY(S) UPON REQUEST OF THE PHYSICIAN(S OR FACILITY(S) FOR THE PURPOSE OF MY TREATMENT:
PHYSICIAN(S) FACILITY(S) NAME:

_____

I AM OVER THE AGE OF 18 OR A PARENT AND/OR GUARDIAN OF A CHILD UNDER THE AGE OF 18 AND AUTHORIZE THE STAFF AND/OR PHYSICIAN(S) AT THIS OFFICE TO DISCUSS MY HEALTHCARE, DIAGNOSIS, TEST RESULTS, PROCEDURES, PROGNOSIS, AND ANY ADDITIONAL ASPECTS OF MY HEALTHCARE, AS WELL AS INSURANCE AND BILLING INFORMATION WITH THE FOLLOWING PERSON(S):
NAME OF INDIVIDUAL: _____ RELATION: _____

NAME OF INDIVIDUAL: _____ RELATION: _____

I AUTHORIZE THE STAFF AND/OR PHYSICIAN(S) TO LEAVE A MESSAGE WITH TEST RESULT AND OTHER LIMITED INFORMATION ON MY PRIVATE VOICEMAIL.
PHONE# _____ ◎ I DENY VOICEMAILS TO BE LEFT.

I AUTHORIZE THE STAFF OF A + ATHLETE SPORTS MEDICINE, LIC TO LEAVE A MESSAGE REGARDING MY PRIVATE HEALTH INFORMATION (CHECK ALL THAT APPLIES)
◎ON MY HOME VOICEMAIL ◎ ON MY CELL PHONE VOICEMAIL. ◎ON MY WORK VOICEMAII
◎ AUTHORIZE THE STAFF TO MAIL WRITTEN COMMUNICATION TO MY HOME ADDRESS. ◎ AUTHORIZE THE STAFF TO SPEAK WITH THE FOLLOWING INDIVIDUALS TO DISCUSS FINANCIAL INFORMATION.
NAME: _____ PHONE: _____
NAME: _____ PHONE: _____

◎I AUTHORIZE THE STAFF TO EMAIL SECURE PATIENT COMMUNICATION AND INVOICES TO THE EMAIL ADDRESS I PROVIDED
EMAIL_____ SIGNATURE_____
RESPONSIBLE PARTY NAME _____SIGNATURE _____

probiCredit Card on File Policy

Effective Date: 11/02/2023

Policy Overview:

At A+ Athlete – Sports Medicine, LLC (the Practice) we are committed to providing quality healthcare services to our patients while efficiently managing our billing and payment processes. To ensure timely and secure payment for services rendered, we have implemented a Credit Card on File Policy. This policy outlines the guidelines and procedures for storing and utilizing credit card information for billing and payment purposes.

This policy applies to all patients who receive professional services and/or related products at A+ Athlete – Sports Medicine, LLC. By providing their credit card information to the practice, patients agree to adhere to the terms outlined in this policy.

Credit Card Information Security:

1. All credit card information provided by patients will be securely stored in compliance with Payment Card Industry Data Security Standard (PCI DSS) requirements.

2. Access to credit card information will be restricted to authorized members who require it for billing and payment processing.

Consent:

By providing your credit card information, you're consenting to the following:

1. A+ Athlete – Sports Medicine, LLC is authorized to charge the credit card on file for any outstanding balances or charges related to medical services received. We will notify you before charging the card on file via email, text message, postal mail, or via verbal communication.

2. A+ Athlete – Sports Medicine, LLC may use the credit card information on file for co-payments, co-insurance, deductibles, and other patient balances / responsibilities owed to the practice. This may include account balances of dependents, such as a child.

Billing Process:

1. Patients will receive an Explanation of Benefits (EOB) from their insurance provider detailing the services rendered and the associated costs. However, our charges and your obligations to our office maybe differ since we are an out-of-network provider.

2. Any outstanding patient responsibilities, including but not limited to co-payments, co-insurance and deductibles, may be charged to the credit card on file after the EOB is processed or 30 days after the date of service if a balance to the practice is due according to our charges.

3. Patients will receive an itemized statement via email or postal mail, showing the charges applied to their credit card.

Updating Credit Card Information:

Patients are responsible for keeping their credit card information up to date. If there are changes to the credit card on file, patients must provide updated information promptly. Otherwise, a service fee for a declined card of $50, plus an administrative fee of $25 may apply and the balance is still due immediately. Delinquent account balances over 30 days past due may be subject to an interest rate penalty of 11.50% and amount similar to Medicare rates of penalty.

Disputes and Refunds:

1. Patients who wish to dispute a charge should contact our billing department within 30 days of the charge appearing on their credit card statement.

Billing@aplusathlete.com or 609-913-2699

2. Refunds, if applicable, will be issued to the original credit card used for payment or written check.

Cancellation of Credit Card on File:

The Credit card on file will remain in effect indefinitely. Patients may request to remove their credit card information from their account at any time by contacting our billing department and providing a written request for credit card information removal from this policy. However, any outstanding balance at that time will be charged. Should a future visit be requested, we will require a new credit card for the patient's account, or payment in full at the time of visit.

Patient's Name_____

Parent/Guarantor Name_____

Signature_____

Date _____