This form to be filled out day of appointment

Per recommendation from the Centers for Disease Control, Towson Sports Medicine is now conducting Travel Screenings.

1) Do you currently have cough, difficulty breathing, or fever
   or at least 2 of the following-
   chills, shaking with chills, muscle pain, headache, sore throat, loss of taste/smell

   Yes No

2) Have you been diagnosed with or tested for COVID-19?

   Yes No

3) Have you had close contact or exposure to someone who may have or is confirmed to have COVID-19?

   Yes No

Signature:____ Date:________________

Name (Printed): ____

TSM CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS

TSM, for the purposes of this consent, includes all physician offices and other facilities providing healthcare services which are part of TSM

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of TSM. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either physician practice care and medical and/or surgical treatment or examinations. If applicable, I give TSM permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize TSM to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

INDEPENDENT CONTRACTORS: I understand that some healthcare providers providing services to me may not be employees of TSM. Some healthcare providers providing services to me may be independent contractors who have been granted the privilege of using the TSM facilities to provide services for and on behalf of TSM. I understand that if the employment status of a healthcare provider is important to me in making treatment and other healthcare decisions, I may inquire as to the employment status of the healthcare provider caring for me.

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to TSM all benefits for care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the TSM is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by TSM, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

PHOTOGRAPHY and/or Video Record: The persons caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission.

PRIVACY OF INFORMATION: (please check √ one)

_________ - I ACKNOWLEDGE receipt of a copy of the Notice of Privacy Practices which explains how TSM may use and disclose protected health information; or

__________ - I REFUSE receipt of a copy of the Notice of Privacy Practices which explains how TSM may use and disclose protected health information.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within TSM, I consent to the program disclosing these records to others within TSM and to other affiliates of University of Maryland Medical System that treat me for purposes of my treatment, quality improvement and other healthcare operations and care coordination. This consent will expire one year after I am no longer a patient of TSM or other affiliates of University of Maryland. I may revoke this consent at any time except to the extent that the program, TSM, or other University of Maryland Medical System affiliates have already acted in reliance on my consent.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees, collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize TSM and its agents to:

a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to TSM at any time associated with me or my account;
b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at TSM or services received at TSM in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by TSM or services to be provided by TSM in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify TSM if any telephone number, email address or other unique electronic identifiers or modes that I provided to TSM change or are no longer used by me.

MISSED APPOINTMENTS

Towson Sports Medicine requires that you give us **24 hours** notice of cancellations. If 24 hour advanced notice is not given, you may receive a **$25** missed appointment fee. Please contact the office ASAP to cancel appointments. This policy does not apply in situations of extreme weather. We also ask that you bring your appointment slip to each appointment. No show appointments will automatically be assessed the $25 fee

Bel Air 410-569-8587
Cockeysville 410-616-1455
Rosedale 410-616-1401
Towson- Bellona Ave 410-337-8847; York Rd 410-337-4024

FINANCIAL RESPONSIBILITY

I understand I am responsible for my account. In the event that my account is referred to a collection agency, there will be a **35% fee** added to the outstanding balance

I certify that I have read this Consent and am the patient OR parent/guardian of the patient OR am duly authorized as patient's agent to execute its terms. By signing below, I represent that the information given by me is accurate to the best of my knowledge.

____
Print Patient Name

______________________________________ ______________________________________
Print Responsible Party Name Relationship to Patient

____
Signature

________________ ____________ ___________________________
Date Time Witness Name & Signature

FORM NOT SIGNED:

_____ REFUSED _____ UNABLE (if unable proceed to verbal consent)

TO BE USED FOR VERBAL CONSENT:

ON ___________________________ AT ________________ O'CLOCK,
DATE TIME

____
Print Name of Person Giving Consent

The terms of this Consent were reviewed with the patient, parent/guardian of the patient, or the duly authorized agent of the patient verbally and such individual provided verbal consent to the terms set forth herein.

_________________________ _________________________
Print Witness Name Witness Signature

TSM complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TSM does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
TSM provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you believe that TSM has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Corporate Compliance and Business Ethics Group, 900 Elkridge Landing Road, First Floor, Linthicum, MD 21090, 410-328-4141, compliance@umm.edu.You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Director is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

DOB____________

Subjective:

Name:____Date____________________Age:______________
Physician:_____________________________Diagnosis:____
Occupation:___________________________________ Currently working? Y N
Demands of the job? ____
Sport/Activity:____

Please circle which body part you are seeking treatment: Left Right
Neck Mid Back Low Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/foot
Other____

Date of injury:_____________ Date of Surgery:____________

What caused your injury or problem?____
____

What is your chief complaint?____

Have you had similar occurrences in the past?____
____

Have you had previous treatment? What kind?___________________________________ When:_______

Circle recent tests- MRI Xrays CT Scan Bone Scan EMG Other________________________________

Medical History (Circle) High Blood Pressure, Diabetes, Arthritis, Osteoporosis/penia, Cancer**,** Allergies, Heart condition, Pace Maker, Stroke, Pregnant, hearing loss, vision loss, memory loss, depression, anxiety currently use tobacco, **Other** (including orthopedic conditions and surgeries):___________________________
____
____
____
____

Pain rating: Indicate your level of pain by circling the appropriate number on the scale:

Worst 0____1____2____3____4____5_____6____7____8____9____10
mild moderate extreme agony

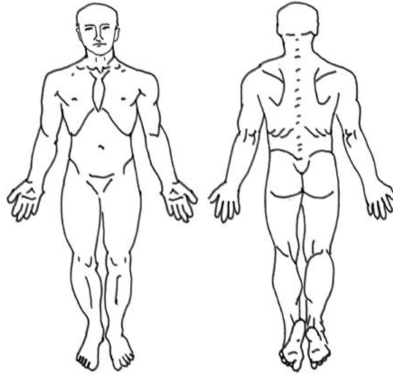
Current 0____1____2____3____4____5_____6____7____8____9____10
mild moderate extreme agony

Best 0____1____2____3____4____5_____6____7____8____9____10
mild moderate extreme agony

TURN PAGE OVER

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness	Pins and Needles	Burning	Stabbing	Aching
===	○○○	xxx	///	***



Does your pain?(circle) Throb Burn Stab Ache Other____

Is your pain constant? Yes No

Does your pain radiate? Yes, where____ No

Numbness, tingling, or weakness? Yes, where____ No

What makes your pain worse? ____
____

What makes your pain better?____
____

What is your goal for your treatment?____

Activities you are limited with due to current injury: self-care, child care, cooking cleaning, shopping, driving, sleeping, recreation other:____
____

When is your next Dr. appt.?_________________

Email (for receipt purposes only):____

Patient Signature:__________________________________ Date:______________________

FOR THERAPIST USE ONLY

Height___________ Weight__________

COMMENTS:____
____
____
____
____
____
____

Therapist Signature______________________________Date____________________

TSM Towson Sports Medicine

University of Maryland Rehabilitation Network

Please provide a list of all your medications including prescription, **over the counter**, vitamins, and supplements, with dosage, frequency, and how administered (oral, injected, etc).

Medication	Dosage	Frequency	How Administered