UND SCHOOL OF MEDICINE & HEALTH SCIENCES
UNIVERSITY OF NORTH DAKOTA
DEPARTMENT OF SPORTS MEDICINE

CENTER FOR SPORTS MEDICINE
HYSLOP SPORTS CENTER RM 144
2751 2ND AVE N STOP 9013
GRAND FORKS ND 58202.9013
P: 701.777.4845 | F: 701.777.2536

PATIENT INFORMATION: (KINDLY COMPLETE ALL FIELDS)

DATE: _____

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: M / F

Permanent Address: _____
STREET CITY STATE ZIP CODE

Grand Forks Address: _____
STREET CITY STATE ZIP CODE

Cell Phone Number: _____ Home Phone Number: _____

Employer: _____ Work Phone Number: _____

Date of Injury: _____ Referring Physician: _____

PARENT/GUARDIAN OF MINOR (under 18 years old):

Parent/Guardian Name: _____ Date of Birth: _____

Address: _____
STREET CITY STATE ZIP CODE

Cell Phone Number: _____ Home Phone Number: _____

Gender: M / F Social Security Number: _____ Relationship to Patient: _____

Employer: _____ Work Phone Number: _____

INSURANCE INFORMATION: Copy of Insurance Card - Front & Back

Primary Insurance: _____ Phone Number: _____

Insurance Address: _____
STREET CITY STATE ZIP CODE

Policy Holder Name: _____ Date of Birth: _____ Gender: M / F

Policy Holder Address: _____
STREET CITY STATE ZIP CODE

Policy Holder Phone Number: _____ Relationship to Patient: _____

Policy/ID Number: _____ Group/Plan Number: _____

Secondary Insurance: _____ Phone Number: _____

Insurance Address: _____
STREET CITY STATE ZIP CODE

Policy Holder Name: _____ Date of Birth: _____ Gender: M / F

Policy Holder Address: _____
STREET CITY STATE ZIP CODE

Policy Holder Phone Number: _____ Relationship to Patient: _____

Policy/ID Number: _____ Group/Plan Number: _____

Other Insurance: _____

UND Student - Athlete? Y / N If yes, team: _____

I hereby authorize the UND Center for Sports Medicine to Communicate Protected Health Information to me via:

☐ Email Initial_____ Email Address: _____

☐ Texting Initial_____ Phone Number: _____

☐ I DO NOT want to be contacted by Email or Texting

**Note: Email is not a secure transmission route. Therefore, we ask you to be cautious of sending sensitive information via email or electronic messaging.*

INSURANCE BENEFITS

I hereby authorize UND Center for Sports Medicine to release information acquired during/after my treatment to my insurance company for billing purposes. This includes all Travel, Canadian, and out of country policies. I agree that my insurance company will make payment directly to UND Center for Sports Medicine. If your insurance company reimburses you directly, it is your responsibility to submit payment to UND Center for Sports Medicine. I understand, I am financially responsible for all charges not covered by my insurance including but not limited to, copays, deductibles, coinsurance, uncovered treatment, etc. This document is a copy of the original and will be treated the same as an original document.

Patient/Parent/Guardian/Responsible Party Signature _____ Date _____

Authorization to Contact Parent/Legal Guardian/Policy Holder

I hereby authorize the UND Center for Sports Medicine to contact my parent(s), legal guardian, or policyholder with questions regarding insurance coverage, demographic information, and payment on account. (If your insurance company reimburses you directly, it is your responsibility to submit payment to UND Center for Sports Medicine. This includes all Travel, Canadian, and out of country policies.)

Patient/Parent/Guardian Signature _____ Date _____

Acknowledgement of Notice of Patient Privacy Practices

☐ **Student/FERPA Privacy Practices**

I acknowledge that I have received a written copy of the University of North Dakota Center for Sports Medicine Notice of Patient Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Patient/Parent/Guardian Signature _____ Date _____

☐ **Nonstudent/HIPAA Privacy Practices**

I acknowledge that I have received a written copy of the University of North Dakota Center for Sports Medicine Notice of Patient Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Patient/Parent/Guardian Signature _____ Date _____

To Be Completed By UND Center For Sports Medicine Staff Only; NO Acknowledgment Can Be Obtained:

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent.
The good faith efforts made, and the reason acknowledgement could not be obtained, were:

☐ **Patient (or authorized agent) refused to sign Notice of Privacy Practices.**
☐ **Other (please describe)**

_____

_____

UND Center for Sports Medicine Staff Signature _____ Date _____