



Orthopedic Knee, Shoulder and Sports Surgery
Michael M. Heckman, M. D., P. A.

PATIENT INFORMATION SHEET

Name: _____ DOB: _____

Address: _____ City and State: _____

Zip Code: _____ Marital Status: S M D W S.S. #: _____

Hm# Phone: _____ Cell #: _____

Emp: _____ Wk #: _____

E-Mail Address: _____

Referred By: _____ Phone: _____ Fax #: _____

IF MINOR: Parent / Guardian: _____ Phone: _____

Address (if different): _____

Emergency Contact: _____ Phone: _____

NOTE:

In order for our office to be as efficient as possible we offer the patient the option to receive a copy of there office report either by regular mail or e-mail. Please choose one: ___ regular mail ___ e-mail

INSURANCE INFORMATION:

****WE WILL REQUIRE A COPY OF YOUR MEDICAL INSURANCE CARD(S) ALONG WITH A COPY OF YOUR DRIVER'S LICENSE.****

Is this a Workers' Compensation Case? ___ Yes ___ No

We will file your private insurance as a courtesy after the patient, responsible party, parent or guardian has either paid the co-pay required, the percentage they are responsible for and / or the deductible not met.

I authorize the assignment of all insurance benefits directly to Orthopaedic Knee, Shoulder, and Sports Surgery / Michael M. Heckman, M.D., P.A. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Print Name of Patient, Parent, Guardian or Personal Representative

Relationship of Patient

Patient Medical History

Name: _____

Date: _____

Referred By: _____

Phone: _____

B/P: _____ Ht: _____ Wt: _____ Pt. referred to: _____

Major Complaint(s) or Injury:

How and when did it happen?

Are there prior injuries to this area(s): Yes No Is this work related? Yes No

Is this a sport injury? Yes No If so, School Name: _____

Is an attorney involved? Yes No If so, name: _____

PAST MEDICAL HISTORY

Are you a DIABETIC? Yes No

Are you Pre / Post Menopausal? Yes No

HEART:

Angina
 Heart Attack
 Arrhythmias
 High Blood Pressure

LUNGS:

Asthma
 COPD
 Tuberculosis
 Pneumonia

KIDNEYS:

Failure
 Infection
 Stones

GASTROINT.

Ulcers
 Bleeding
 Hepatitis
 Gallbladder

ARTHRITIS:

Rheumatoid
 Degenerative
 SLE

NERVOUS SYSTEM: Other Problems Not Listed:

Stroke
 Seizures
 Depression

Surgery History-Please Indicate Date, Hospital and Procedure:

DATE

HOSPITAL

PROCEDURE

List All Medications, Nutritional, or Herbal Substances You Are Presently Taking:

Name

Dosage

How Often

Medication Allergies:

Do you smoke? ___ Yes ___ No

If so, how many packs a day: _____

Do you drink alcohol? ___ Yes ___ No

If so, how often: _____

NOTES:

Signature

Date

Orthopedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

HIPAA Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and /or administrative and clinical staff to (check all that apply):

___ Use the following protected health information, and /or

___ Disclose the following protected health information to **Orthopaedic Knee, Shoulder, & Sports Surgery / Michael M. Heckman, M.D., P.A.**

Information is to be limited specifically to services performed by **Orthopaedic Knee, Shoulder, & Sports Surgery / Michael M. Heckman, M.D., P.A.**

This protected health information is being used or disclosed for the following purposes: At the request of the patient.

For assignment of medical insurance benefits to the physician or physicians that rendered treatment. I understand that I am financially responsible for all charges whether or not paid by said insurance. (Initial's: _____)

I consent to the release of any medical information to my insurance companies, durable medical provider, other physicians rendering medical treatment, physical therapy/rehabilitation, laboratories, coaches, trainers and any ancillary services. (Initial's: _____)

This authorization shall be enforced and effective until one year after the date of signature, at which time this authorization to use or disclose this protected health information expires. (Initial's: _____)

I understand that I have the right to revoke this authorization in writing any time by sending such written notification to the practice's Privacy Contact at the office of **Orthopaedic Knee, Shoulder, & Sports Surgery / Michael M. Heckman, M.D., P.A.**, 9150 Huebner Rd. #330, San Antonio, Texas 78240. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. (Initial's: _____)

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may not longer be protected by federal or state law. (Initial's: _____)

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. (Initial's: _____)

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Orthopedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

Dear Patient:

Physicians have always protected the confidentiality of health information by securing medical records and refusing to reveal your information except as when necessary to provide medical care. Today, state and federal laws also attempt to ensure the confidentiality of your personal medical information.

The Federal Government recently published regulations for the protection of your health information. This “privacy rule” protects health information that is maintained by physicians, hospitals, other health care providers (i.e. physical therapy, laboratory facilities), and health plans. Effective April 13, 2003, physicians must comply with the privacy rules and regulations for protecting the confidentiality of your health information.

This new regulation protects every patient who is seen by a physician, hospital, or other health care provider, and all health information, including paper records, oral communications, and electronic formats (such as e-mails or faxes) are protected by the privacy rule.

This privacy rule also provides certain rights to the patients, such as the right to have access to your medical records. However, these rights are not absolute; there are exceptions. We take precautions in our office to ensure that your medical information is protected and is not accessible to persons outside of the office environment by training our office personnel and instituting computer security measures.

The Notice **of Privacy Practices** attached to this letter explains our privacy practices. It contains important information about how your health information is protected in our office. It also explains how you can exercise your rights with regard to your protected health information.

Please feel free to ask any questions that you have regarding these privacy rules and our practices for enforcement of these rules. You may speak with the Privacy Office during regular business hours at 558-4600, or you may discuss your questions with your physician.

Michael M. Heckman, M.D., P.A. and Staff

Orthopedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you may get access to this information. Please review it carefully.

If you have any questions about this notice, please contact our Privacy Officer, Norma Garza.

This notice of privacy practices describes how we may use and disclose your protected medical information to carry out treatment, payment, or health care operations, 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 your demographic information, that may identify you as it relates to your past, present, and future physical or mental health or condition.

Our responsibilities

We are required by law to maintain the privacy of your health information, and to abide by the terms of this Notice of Privacy Practices. However, at our discretion, we may change the terms of this notice at any time. Upon your request, this office will provide you with any revisions of the Notice of Privacy Practices, which would apply to all protected health information that we maintain at this time.

Uses and Disclosures

How we may use and disclose Medical Information about you with your written consent.

You will be asked by your physician to sign a consent form. This allows your physician to use and disclose your protected health information for treatment, payment, and health care operations as described in Section I. Your protected health information may be used and disclosed by your physician, his office staff, and others outside of this office who may be involved in your care and treatment, for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills.

Attached are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make once you have signed our consent form. These examples are meant to inform you as to the types of uses and disclosure that may be made by this office in the course of providing you medical care.

For Treatment

We may use your medical information to provide treatment and services to you. We may disclose medical information about you to other physicians, medical students, or other health care personnel who are involved in your medical care, either directly or indirectly.

For example, we would disclose your protected health information to a physical therapy facility, pharmacy, or your case manager, as necessary, so that they could understand your condition and treat as appropriate, per your doctor's instruction.

For Payment

We may use and disclose protected health information about you to bill and collect payment from you, your insurance carrier, or a third party payer. For example, we may need to provide surgery information to your insurance company so that they will pay us or make reimbursement to you for treatment provided. We may also need to provide your insurance company with any subsequent treatment plans to determine if your insurance plan will cover these treatment plans.

For Health Care Operations

We may, as necessary, use or disclose your protected health information in order to support the business activities of this office, such as for assessment of quality assurance, and or the education and training of supportive medical personnel. This will allow us to continually improve the quality of care for all of our patients. We may use and disclose your protected health information, when necessary, to other business associates with whom we are contracted to perform agreed upon services and billing for such services, such as outside transcriptions services or medical records services.

Also, we may have a sign-in sheet at the check-in desk where you will be asked to sign your name. We may also call you by name in the reception area when your physician is ready to see you. We may, when necessary, use or disclose your protected health information to contact you regarding an upcoming appointment.

Uses and Disclosures of Protected Health Information Based upon your Written Consent

Other uses and disclosures of your protected health information will be made only upon your written consent, unless otherwise permitted or required by law as outlined below. You have the option to revoke this consent at any time, in writing, except to the extent that your physician or his practice has taken an action in reliance on the use and disclosure indicated in the consent.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

We may use and disclose your protected health information in the following instances. You have the right to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use and disclosure of your protected health information, your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the pertinent, relevant, and necessary medical information will be disclosed.

Others involved in Your Healthcare

Unless you object, we may disclose to any member of your family, a relative, a close friend, or any other person you identify, your protected health information as it directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose this information, as necessary, if we determine, by our professional judgment that this is in your best interest to do so. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care of your location, general health, or death. Additionally, we may use or disclose your protected health information at an authorized public or private health entity to assist in disaster relief efforts.

Emergencies

We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician will try to obtain your consent as soon as reasonably practical after the delivery of treatment. If your physician or another physician involved in your medical care is required by law to treat you, and the physician has made reasonable attempts to obtain your consent from you, he or she may still use or disclose your protected health information to provide medical treatment.

Communication Barriers

We may use and disclose your protected health information if your physician or other physician involved in your care attempts to obtain consent from you but is unable to do so because of substantial communication barriers, and the physician determines by his professional judgment that you intend to use or disclosure under these circumstances.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following instances without your consent or authorization. These situations include:

Required by Law

We may use or disclose protected health information to the extent that the use or disclosure is required by law, to such entities including but not limited to:

- .Food and Drug Administration –to report adverse events, product defects or problems, biologic product deviations, to enable product recalls, or to conduct post-marketing surveillance, as required.
- .Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- .Correctional Institutions –we may use or disclose your protected health information if you are an inmate or a correctional facility, and your physician created or received your protected health information in the course of providing care to you.

Workers Compensation Agents –your protected health information may be disclosed by us as authorized to comply with Workers Compensation laws and other similar legally established programs.

Military Command Authorities –when the appropriate conditions apply, we may use or disclosed protected health information of individuals who are Armed Forces personnel; 1) for activities deemed necessary by appropriate military command authorities; 2) for the purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits, or; 3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conduction national security and intelligence activities, including for the provision of protective services to the President and others legally authorized. Funeral Directors, Coroners, and Medical Directors

You will be notified, as required by law, of any such uses or disclosures.

Health Oversight

We may use or disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, or inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

Abuse or Neglect

We may use or disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. Additionally, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to a governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings

We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order or a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement

We may disclose protected health information for law enforcement purposes as required by law or in response to a valid subpoena so long as applicable legal requirements are met, for law enforcement purposes only. These law enforcement purposes include:

- 1) Legal processes otherwise required by law.
- 2) Limited information requests for identification and location purposes.
- 3) Pertaining to victims of a crime,

- 4) Suspicion that death has occurred as a result of criminal conduct,
- 5) In the event that a crime occurs on the premises of the practice, and
- 6) Medical emergency (not on the practice's premises), and the likelihood that a crime has occurred.

YOU'RE RIGHTS

Following is a statement of your rights with respect to your protected health information, and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set, as long as we maintain the protected health information. A "designated record set" contains medical records and billing information, and any other records that your physician and the practice uses for making decisions about your medical care.

Under federal law, however, you may not inspect or copy the following records:

- 1) Psychotherapy notes, 2) information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, 3) protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable, and you may have the right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to our medical records.

You have the right to request a restriction of your protected health information.

This means that you may ask us to not use or disclose any part of your protected health information for the purpose 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 the specific restriction requested, and to whom you want the restriction to apply.

However, your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted. If your physician does agree with the requested restriction, we may not use or disclose your protected health information, unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by formal notification in writing to your physician.

You have the right to request confidential communications from us by alternate means or at an alternate location.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information.

This means that you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical records.

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

This right applies to disclosures made for purposes other than treatment, payment, or healthcare operations, as described in this Notice of Privacy Practices. It would not include disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

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 electronically.

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 Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Office, **Norma Garza**, at (210) 558-4600 for further information about the complaint process.

This notice was published and became effective on April 14, 2003.



Orthopaedic Knee, Shoulder and Sports Surgery

9150 Huebner Rd., # 330

Phone #: 210-558-4600

San Antonio, Texas 78240

Fax #: 210-558-4605

Information the Patient Should Know About Our Office

Dr. Michael Heckman is a provider of **some** PPO insurance companies. It is your responsibility to know your policy and contract. Although we are here to assist you as we can, we do not have knowledge on your personal policy and contract.

• If we are Providers...

If we are providers on your insurance, **you, the patient, the parent or guardian (if patient is a minor)**, are responsible for your co-pay, deductible and / or your percentage at the time of the visit. We will file your claim with the carrier.

If Dr. Heckman refers you to another physician it is **your responsibility** to confirm with your carrier that the physician is a provider under your plan. Since there is always a new doctor being approved as a provider or doctors that no longer wants to be providers, we can not keep up with these changes. When contacting your carrier, for your protection, make sure you document the person you spoke with, and ask for a confirmation or authorization number to reference the conversation. This will assist you if the carrier decides to deny coverage.

• If we are Non-Providers....

If we are non- providers under your insurance, that means that you will be seeing the doctor out-of-network. Please understand that we will be more than happy to have you as a patient, but your coverage will be different under your plan. For example, if you're current coverage is 90% / 10%, coming to a physician who is a non-provider can change your coverage to a lower reimbursement percentage. (You must call your carrier to inquire on your out-of-network coverage.) Therefore, you will be responsible to pay your deductible and / or your percentage under your plan at the time of the visit. We will file your claim to the insurance company as a courtesy.

* Patient's with Indemnity Coverage...

You will be responsible to pay your deductible and / or your percentage under your plan at the time of the visit. We will file your claim to the insurance company as a courtesy.

*** Self-Pay Patients...**

Self-pay patients do not have any type of insurance coverage and **will be required to pay in full** at the time of the visit.

• Patient's with an HMO Coverage...

Dr. Michael Heckman is a provider for some HMO plans. It will be your responsibility to make sure that we have received the referral form that will give us authorization to see you. Otherwise, you will be solely responsible on the day of service for all charges.

• Notice of Billing Statements...

Billing statements are sent out every **other** month. But you, the patient are still responsible to keep up with your account. It is up to you to know what your insurance has paid or not paid. **Ultimately, the balance is your responsibility.**

****Please be aware that we accept checks, cash, Visa and Mastercard.****

****There will be a \$25.00 return check fee.****

We appreciate your cooperation. If you have any questions please do not hesitate to ask.

OFFICE ADDRESS AND HOURS

**Orthopaedic Knee, Shoulder, and Sports Surgery
Michael M. Heckman, M.D., P.A.
9150 Huebner Rd.
Suite #: 330
San Antonio, Texas 78240**

**Office #: 210-558-4600
Fax #: 210-558-4605**

**Monday – Friday
8:00am – 5:00pm**

HOTEL INFORMATION

Some patient's come in from out of town and need a hotel close to the office or hospitals in the medical center area. We have found three hotels that will offer medical rates to patients.

While making the reservations ask them about there medial rates; each one will explain their policy and rates.

The hotels are as follows:

**Marriott – Courtyard
7401 Wurzbach Rd.
(210) 614-7000**

**Howard Johnson
7041 Wurzbach Rd.
(210) 614-9900**

**Regency Inn & Suites
9797 Fredericksburg Rd.
(210) 690-2255**