Orthopedic Knee, Shoulder and Sports Surgery

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

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Orthopaedic Knee, Shoulder & Sports Surgery** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Orthopaedic Knee, Shoulder & Sports Surgery** I understand that diagnosis or treatment of me by **Orthopaedic Knee, Shoulder & Sports Surgery** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Orthopaedic Knee, Shoulder & Sports Surgery** is not required to agree to the restrictions that I may request. However, if **Orthopaedic Knee, Shoulder & Sports Surgery** agrees to a restriction that I request, the restriction is binding in the office of **Orthopaedic Knee, Shoulder & Sports Surgery.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Orthopaedic Knee, Shoulder & Sports Surgery** has taken action in reliance on this consent.

My "protected health information" (PHI), means health information, including my demographics information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Orthopaedic Knee, Shoulder & Sports Surgery.** Notice of Privacy Practices prior to signing this document. ****Orthopaedic Knee, Shoulder & Sports Surgery.** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the practice. Notice of Privacy Practices for **Orthopaedic Knee, Shoulder & Sports Surgery** is provided at 9150 Huebner Rd. Suite 330, San Antonio, Texas 78240. This Notice of Privacy Practices also describes my rights and the duties of **Orthopaedic Knee, Shoulder & Sports Surgery** with respect to my protected health information.

Orthopaedic Knee, Shoulder & Sports Surgery reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice or privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at he time of my next appointment.

Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
Date	Description of Personal Representative's Authority

9150 Huebner, Suite 330 San Antonio, Texas 78240 **Phone: 210-558-4600** **Fax: 210-558-4605**

Website: www.sanantoniosportsmedicine.com

Orthopaedic Knee, Shoulder and Sports Surgery

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

PLEASE READ THIS THOROUGHLY AND CAREFULLY

HIPAA: Health Insurance Portability and Accountability Act

HIPAA was designed for the privacy of patients who are under the care of physicians. Although you have signed the "Release of Records to Insurance," this form will allow us to release information and/or records to anyone specific, other than the insurance company. In addition to the insurance company, I authorize to the release of my medical records to:

Primary Care Physician_____
Spouse_____
Family Member_____
Coach/Trainer_____
Adjuster(WC Only)_____
Nurse Case Manager(WC Only)_____
Other(Please Specify)_____

I understand that I have the right to revoke this consent, if I so decide to. I understand that if I would like to make changes to this form I must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian if patient is minor/indigent Date

Orthopaedic Knee, Shoulder and Sports Surgery (OKSSS)

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

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2003

Purpose of Notice

Orthopaedic Knee, Shoulder and Sports Surgery (OKSSS) is required by both federal and state law, as pertaining to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Regulations"), to protect the privacy about a patient or a patient's health information. In addition, we are required to provide you with this Notice of Privacy Practices (the "Notice") regarding our legal obligations with respect to our privacy practices concerning your protected health information and to abide by the terms of its Privacy Notice currently in effect. This Privacy Notice is intended to describe both the obligations of this practice with respect to information that it has about you and your rights with respect to that information. Reference to "Orthopaedic Knee, Shoulder and Sports Surgery" or Michael M. Heckman, M.D., in this Notice refers to OKSSS that has protected health information about you. Our employees, staff, and the other healthcare professionals providing services to you in our office are subject to this Notice of Privacy Practices.

What is Protected Health Information?

Health information is broadly defined as any information, whether oral or recorded in any form or medium that is created or received by OKSSS whether the information relates to your past, present or future physical or mental health or condition, the provision of healthcare to you, or the past, present or future payment for the provision of healthcare to you. Individually identifiable healthcare information is information that includes health information and also includes demographic information collected from you that identifies you or which reasonably can be used to identify you. This is generally referred to throughout this Notice as *protected health information* or "*PHI*." The Practice is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice setting forth our legal duties with respect to your PHI.

This Notice describes how Orthopaedic Knee, Shoulder and Sports Surgery (OKSSS) will use and disclose your health information, whether recorded in your medical record, invoices, payment forms, videotapes or other ways.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:

In certain circumstances, OKSSS is permitted or required to use or disclose your health information without obtaining your prior authorization and without offering you the opportunity to object, including:

1. **Permitted Uses and Disclosures:**

    a. Uses or disclosures for purposes relating to treatment, payment and health care operations:

        i. Treatment. OKSSS may use or disclose your health information for the purpose of providing, or allowing others to provide, treatment to you. An example would be if your primary care physician discloses your health information to another doctor for the purposes of a consultation. Also, OKSSS may contact you with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

ii. Payment. OKSSS may use or disclose your health information for the purpose of allowing OKSSS, as well as other entities, to secure payment for the health care services provided to you. For example, MMC may inform your health insurance company of your diagnosis and treatment in order to assist the insurer in processing OKSSS's claim for the health care services provided to you.

iii. Health Care Operations. OKSSS may use or disclose your information for the purposes of OKSSS's day-to-day operations and functions. For example, MMC may compile your health information, along with that of other patients, in order to allow a team of OKSSS's health care professionals to review that information and make suggestions concerning how to improve the quality of care provided by OKSSS.

b. When required to do so by federal, state or local law;

c. For public health purposes, such as any required or permitted disclosure to report diseases, injuries, or vital statistics, or reactions to medications or problems with products or to notify people of recalls of products they may be using, or who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

d. To disclose information about victims of abuse, neglect, or domestic violence;

e. To disclose to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

f. For judicial or administrative proceedings, such as any lawsuit in which your health information is relevant to the proceedings;

g. To law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

h. To assist coroners, medical examiners or funeral directors with their official duties;

i. To facilitate organ, eye or tissue donation;

j. When instances of imminent and serious threat exists as to your health or safety or that of the public or another person;

k. For specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and

l. For workers' compensation purposes, as permitted by Texas law.

2. **Other Permitted Uses and Disclosures:**

To the extent authorized by law, we may disclose your health information to your family or other individuals identified by you when they are involved in your care or the payment for your care. We will only disclose the health information directly relevant to their involvement in your care or payment. We may also use or disclose your health information to notify a family member or another person responsible for your care of your location, general condition or death. We will determine whether a disclosure to your family or friends is in your best interest, and then, to the extent allowed by law, we will disclose only the health information that is directly relevant to their involvement in your care.

Research. The Practice may use your PHI for research purposes if we have de-identified the information so that the information provided could not reasonably be associated with you. Our personnel may use your PHI in the process of de-identifying your PHI for this purpose. For all other types of research, we will usually ask for your authorization before using your PHI for research purposes. However, we may use and disclose your PHI without authorization if the applicable institutional review board that oversees research involving human subjects has waived the authorization requirement.

Uses and Disclosures to Business Associates. OKSSS may engage a certain persons or organizations to perform certain functions of our practice on our behalf, and we may disclose certain health information to these persons as Business Associates. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. For example, we may share certain PHI with our billing company in order to facilitate our healthcare operations or payment for services provided in connection with your care. In this connection, we will require our Business Associates to enter into an agreement to keep your PHI confidential and to abide by the terms set forth in this Privacy Notice. Additional Business Associates include, but are not limited to, consultants, accountants, lawyers, and medical transcriptionists.

Incidental Disclosure. Certain disclosures may occur incidentally. For example, conversations regarding your medical care may be overheard by other persons or patients in the office or someone may view your name on the sign-in sheet in the waiting area. OKSSS will use its best efforts to limit these disclosures, but the efficient delivery of medical care in our office setting will not permit incidental disclosures to be totally eliminated.

Except as described above, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless OKSSS has taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

YOUR RIGHTS:

1. To Request Restrictions. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment or health care operations purposes or notification purposes. OKSSS is not required to agree to your request. If OKSSS does agree to a restriction, it will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, obtain a OKSSS form and submit that form to the Medical Assistant.

2. To Confidential Communications. You have the right to receive confidential communications about your own health information. This means that you may, for example, designate that we contact you only via e-mail, or at work rather than home. To request communications via alternative means or at alternative locations, obtain a OKSSS form and submit that form to the Contact Person listed on the final page of this Notice.

3. To Access and Copy Health Information. You have the right to inspect and copy most health information about you. To arrange for access to your records, or to receive a copy of your records, obtain a MMC form and submit that form to the Medical Records staff. If you request copies, you will be charged OKSSS's regular fee for copying and mailing the requested information.

4. To Request Amendment. You may request that your health information be amended. Your request may be denied under certain circumstances. If your request to amend your health information is denied, you may submit a written statement disagreeing with the denial, which OKSSS will keep on file and distribute with all future disclosures of the information to which it relates. To amend any information, obtain a OKSSS form and submit that form to the Contact Person listed on the final page of this Notice.

5. To an Accounting of Disclosures. You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment,

payment or health care operations, (ii) disclosures made to you, (iii) disclosures of information maintained in OKSSS's patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vi) disclosures that occurred prior to April 14, 2003, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are incidental to another permissible use or disclosure, or (ix) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks OKSSS not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosures, obtain a OKSSS form and submit that form to the Contact Person listed on the final page of this Notice.

6. To a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice upon request or a copy can be obtained at our website: www.oksss.com.

OKSSS's DUTIES:

1. OKSSS is required by law to maintain the privacy of your health information and to provide you with this Notice of its legal duties and privacy practices.

2. OKSSS is required to abide by the terms of the Notice currently in effect. OKSSS reserves the right to change the terms of this Notice and to make those changes applicable to all health information that MMC maintains. Any changes to this Notice will be posted at OKSSS and will be available upon request.

COMPLAINTS:

You can complain to OKSSS and to the Secretary of the Department of Health and Human Services 200 Independence Avenue, S.W., Washington, D.C. 20201 if you believe your privacy rights have been violated. To make a complaint to OKSSS, please file a written complaint with the Contact Person set forth below. This Contact Person will also provide you with further information about OKSSS's privacy policies upon request. No action will be taken against you for filing a complaint.

DESIGNATED CONTACT PERSON:

Carrie Carrillo-Heckman BSN, RN c/o Orthopaedic Knee, Shoulder and Sports Surgery, 9150 Huebner Rd. Suite #330,San Antonio, Texas 78240 Phone: (210) 558-4600

Orthopaedic Knee, Shoulder and Sports Surgery

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

PLEASE READ THIS THOROUGHLY AND CAREFULLY

If you are Workman's Comp, please disregard the Notification of Financial Responsibility and the Statement of Financial Responsibility, HOWEVER please review and sign the Release of Records to Insurance portion.**

Notification of Financial Responsibility

All patients are financially responsible for the payment of services rendered by Michael M. Heckman M.D. Payment is expected at the time services are rendered, unless arrangements are made prior to the visit. This includes co-pays, deductibles and coinsurance. There is also a responsibility to provide payment for any remaining account balances, there may be on your account.

If payment is not rendered for your account, interest will begin to accumulate. After 90 days of overdue payments. A **12% interest rate will be added to the past due balance.** After 120 days, your account will be sent to a collection agency and there will be a **35% collection fee added to your existing balance.** All return checks will result in a $25.00 charge to your account.

Statement of Financial Responsibility

I have carefully read and understand that I_____ am financially responsible for the payment of all charges pertaining to the services rendered by Michael M. Heckman M.D.

Guarantee of Payment

Please Initials

_____ I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

_____ I have been advised that if my health insurance carrier/PPO/HMO/Medicare plan claims that the services I received today are not conserved reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize the services that I am requesting and receiving today. I have been advised that if I did not notify my PCP in advance for a referral authorization my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

_____ I understand that if my insurance company does not deem the services I received as "a covered benefit" I will be responsible for payment of these services.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. If insurance does not pay in a timely manner (within 90 days of the date of insurance filing) the guarantor will be expected to pay the balance and then pursue reimbursement from the insurance company.

_____ _____

Signature of Patient Date

_____ _____

Signature of Guarantor (If patient is a minor/indigent) Date

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Orthopaedic Knee Shoulder and Sports Surgery

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

PERMISSION FOR RELEASE OF MEDICAL RECORDS

As a service to our patients we will be happy to forward your medical records after each office visit to either an email address or a fax number of your choice. Please instruct us as to how and where you would like to receive your records. By allowing the practice to forward your records be advised that the email or fax number that you are selecting to use should be controlled and secure to the extent that you are comfortable having personal medical information forwarded. Because email does not currently meet with HIPAA compliance, our office and staff will have no liability associated with any disclosure of your personal medical information to any other individual once we are directed by you as noted below:

Personal Fax Number:_____

OR

Personal E-mail Address:_____

_____ _____
Signature of Patient Date

Notice of Privacy Practices & HIPAA: Please initial to confirm that you have reviewed a copy of the Notice of Privacy Practices & HIPAA.

Patient Initials: _____ Date: _____ Chart Number: _____

Preferred Language: _____ Ethnicity: _____ Race: _____

Preferred Pharmacy: _____ Phone: _____

Orthopaedic Knee, Shoulder and Sports Surgery

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

"No-Show" Policy

NOTICE TO PATIENTS:

ORTHOPAEDIC KNEE SHOULDER & SPORTS SURGERY HAS A NEW POLICY FOR PATIENTS WHO MISS THEIR SCHEDULED APPOINTMENTS. OUR NEW POLICY CONSISTS OF THE FOLLOWING:

1. **THE PATIENT IS RESPONSIBLE FOR NOTIFYING THE OFFICE 24 HOURS IN ADVANCE TO CANCEL THEIR APPOINTMENT.**

2. **IF YOU FAIL TO NOTIFY THE OFFICE AND "NO SHOW" FOR YOUR APPOINTMENT YOUR ACCOUNT WILL BE CHARGED A $20.00 "NO SHOW" FEE.**

3. **FUTURE APPOINTMENTS WILL *"NOT"* BE SCHEDULED UNTIL PAYMENT HAS BEEN RECEIVED.**

EFFECTIVE MAY 19, 2008

_____ _____

Patient or Guardian Signature **Date**

_____ _____

Witness **Date**

9150 Huebner Suite: 330 San Antonio, Texas Phone: (210) 558-4600 Fax: (210) 558-4605

Website: www.sanantoniosportsmedicine.com

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

Patient Information			
Name Last	First	Mi	Address
City	State	Zip	Phone
			( )
DOB	Marital Status	Sex	Cell Phone
/ /	S M D W	Male Female	( )
Social Security #	Occupation	Employer	Work Phone
- -			( )

Emergency Contact Information			
Name Last	First	Mi	Phone
			( )

Insurance Information			
Insured Name Last	First	Mi	Social Security
			- -
Primary Insurance	ID Number	Group Number	DOB
			/ /
Secondary Insurance	ID Number	Group Number	Is the insured name on the secondary the same as the first? Yes or No
Work Related Injury Yes / No	Name of Employer	Phone #	Date of Injury: / /
Employer Address	City/State/Zip		Name & Telephone # for Case Manager &/or Adjustor:

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print Name of Patient, Parent, Guardian or Personal Representative Date

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Orthopaedic Knee Shoulder & Sports Surgery

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

Past Medical History

Date: _____ Patient Date of Birth: _____ Age:_____

Patient First Name: _____M.I._____Last:_____

B/P:_____ Ht: _____ Wt: _____ Pulse_____

Primary Care/Family Doctor: _____Referred By: _____

Major Complaint(s) or Injury: Knee: Right Left Shoulder: Right Left
Hand/Wrist: Right Left Elbow: Right Left Hand Dominance: Right HD Left HD Ambidextrous

Problem:_____

_____

_____

How and when did it happen? _____

Are there prior injuries to this area(s): ____ Yes ____ No

Is this work related? ____Yes ____ No If yes, Date of Injury_____

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

Is an attorney involved? ____ Yes ____No If so, name: _____

SOCIAL HISTORY:

Do you smoke? ___ Yes ___ No ___ Never If so, how many packs a day:___for # years:___ # years quit?___

Do you drink alcohol? ___ Yes ___No If so, how often: _____

Do you have a history of drug or alcohol abuse? ____Yes ____No If yes, what? _____

Occupation (Status): _____ Date last worked: _____

Special Diet: _____

_____ _____ _____
Signature **Date** **Physician Initials**

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Orthopaedic Knee, Shoulder and Sports Surgery

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

Patient Medical History: 2

Hospitalizations/Surgery History: Please indicate ANY hospitalizations or surgeries you have had in the past please include Date, Hospital and Procedure. If you cannot recall the exact date, then please give us the approximate time frame.

Date **Hospital** **Procedure**

_____
_____
_____
_____
_____

Please list ALL medications you are currently taking, please include Nutritional, or Herbal Substances.

Name **Dosage** **How Often**

_____
_____
_____
_____
_____

Please list any known allergies to medications, latex, foods, shellfish, tape products, or other substances.

Allergy	Reaction

Please list family history of diseases and include any diseases related to your current problem.

Member	Alive	Disease History (cause of death)
Grandmother: Mother	Yes/No	
Grandmother: Father	Yes/No	
Grandfather: Mother	Yes/No	
Grandfather: Father	Yes/No	
Mother	Yes/No	
Father	Yes/No	
Sister/Brother	Yes/No	
Sister/Brother	Yes/No	
Other		

_____ _____ _____

Signature **Date** **Physician Initials**

Orthopaedic Knee Shoulder & Sports Surgery
Patient Medical History
Michael M. Heckman M.D.,P.A.

Musculoskeletal/Joints
- Muscular Disease
- Gout
- Arthritis
  - Rheumatoid
  - Degenerative
  - SLE
  - Fibromyalgia

Metabolic Problems
- Diabetes
- Thyroid ____Hypo _____Hyper

Urinary Problems
- Urination Problems
- Prostate Disease
- Kidney Disease
- Kidney Failure
- Kidney Infection
- Kidney Stones

Cardiovascular Problems
- Angina
- Heart Attack
- Chest Pain
- Mitral Valve Prolapse
- Irregular Heartbeat
- High Blood Pressure
- Shortness of Breath
- Pacemaker

Gastrointestinal Problems
- Stomach Ulcers
- Gallbladder Problems
- Pancreatitis
- Colitis
- Blood in Stool
- Hiatal Hernia
- Liver Disease
- Constipation
- Loss of Bowel Control
- Hepatitis
  - A
  - B
  - C
- Jaundice

Immunological Diseases
- HIV Virus
- AIDS Virus

Neurological Problems
- Headaches
- Migraines
- Seizures
- Epilepsy
- Strokes
- Depression

Bleeding Disorders
- Anemia
- Blood Clots
- Bleeding Problems

Respiratory Problems
- Asthma
- Bronchitis
- COPD
- Emphysema
- Pneumonia
- Tuberculosis

Reproductive System
- Infections
- Herpes
- Venereal Disease

Cancer
- Lung
- Breast
- Colon/Intestinal
- Stomach
- Prostate
- Skin
- Kidney
- Bone
- Other Malignancy

WOMEN Only
- Endometriosis

Are you currently taking birth control?
____Yes ____No
Are you currently pregnant?
____Yes ____No
Are you currently trying to conceive?
____Yes ____No

_____ _____ _____
Signature **Date** **Physician Initials**