Sports and Regenerative Medicine

HECKER®

2315 E Harmony Rd Ste 130 - Fort Collins, CO 80528
Ph: 970-631-8877 - Fax: 970-672-8885

PATIENT DEMOGRAPHICS: **DATE:**_____

First Name:_____MI:_____Last Name:_____

DOB:_____/_____/_____ SSN:_____-_____-_____ Gender: M / F

Mailing Address:_____City:_____State:_____Zip:_____

Phone (home)_____(cell)_____(work)_____

Email:_____Employer:_____

Emergency Contact:_____Phone:_____Relationship:_____

Primary Care Doctor :_____Phone:_____

Would you like us to send copies of office notes to your primary care doctor? YES_____ NO_____

GUARANTOR (Responsible party for minors)

First Name:_____MI:_____Last Name:_____

DOB:_____/_____/_____ SSN:_____Relationship to Patient:_____

Mailing Address:_____City:_____State:_____Zip:_____

PRIMARY INSURANCE & POLICY HOLDER

Insurance Name:_____Member ID:_____Group Number:_____

Policy Holder:_____DOB: _____/ _____/____ SSN:_____Phone:_____

Relationship to Patient: _____ Mailing Address (if different):_____

City:_____State:_____Zip:_____

SECONDARY INSURANCE & POLICY HOLDER

Insurance Name:_____Member ID:_____Group Number:_____

Policy Holder:_____DOB: _____/ _____/ _____SSN:_____ Phone:_____

Relationship to Patient: _____ Mailing Address (if different):_____

City:_____State:_____Zip:_____

WORKER 'S COMP / AUTO/ LIABILITY ACCIDENT:

Date of accident: _____ Employer: _____

Type of accident: Auto / Work / Home Other: _____

Referring Doctor:_____

Adjuster's name:_____Phone:_____

Claim # / Insurance name:_____

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PATIENT INTAKE FORM

Name: _____ Date: _____

Shoe Size:_____

Local Pharmacy: _____ Address:_____

Reason for visit_____

Was this an Injury: Y / N Is Injury Work Comp: Y / N Date of Injury: _____

IF Work Comp, Employer at time of Injury: _____

Please circle if you are interested in any of the following:

Piezo Shockwave *Low Light Laser* *Winback* *Amniotic Stem Cell Injection* *Prolotherapy*

Other Alternative Treatments:_____

Current Medications:
What medications are you currently taking? Please include over the counter and supplements. **Include strength and dosage**.

_____

_____

_____

Current and Ongoing Medical Problems:
Please list **ALL** current and ongoing medical issues. If you have listed any current medications above, please provide the health condition you are taking them for.

_____

_____

_____

Allergies:

_____

_____

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PATIENT INTAKE FORM

Patient Name: _____ Date: _____

Past Surgical History:

_____

_____

_____

Family History/Major Illness:

_____

_____

Social History:

Do you use Tobacco?	Y / N	If yes, what kind,
Do you drink alcohol?	Y / N	If yes, how frequently?
Do you use recreational drugs?	Y / N	
Do you use marijuana?	Y / N	

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PATIENT NAME:_____ RESPONSIBLE PARTY:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered or provided a copy of Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine, notice of privacy practices.

CONSENT TO TREAT

I authorize Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine, to render services as deemed necessary for the care of the above-named patient.

HIPAA MEDICAL INFORMATION RELEASE

I authorize the release of information from Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine, including the diagnosis, records, examinations, and claims/billing information, to the following people *(please select one or more, and include names)*:

[ ] Patient's spouse: _____
[ ] Patient's child(ren): _____
[ ] Other: _____
[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Your signature below indicates:

1. *You read and understand the Acknowledgement of Receipt of Notice of Privacy Practices*
2. *You understand and agree to the Consent to Treat*
3. *You read and understand the Medical Information Release*

_____ _____

Signature (Patient or Responsible Party) Date

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ASSIGNMENT OF MEDICAL INSURANCE BENEFITS

Thank you for choosing Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine. Please understand our office policy regarding insurance assignment. Your insurance plan is an agreement between you and your insurance company to pay certain amounts for your medical care. We strive to assist you in this process and will submit insurance claims on your behalf to *in-network plans*, this includes secondary and supplemental plans. We ask that you assign these insurance payments directly to our practice.
If we are *out of network* with your plan, we will be happy to provide you with an itemized statement for you to submit to your insurance and those claims will be applied to your out of network benefits.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE unless we accept assignment with your insurance company or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you READ AND SIGN THE FOLLOWING:

I acknowledge that it is my responsibility to:

1. Present a valid insurance card at the time of service. If I neglect to do so, I am responsible for the full cost of the visit.
2. Pay applicable co-pay or non-covered services at the time of service.
3. Present a valid referral or authorization for all services (if required by my insurance company). If I neglect to have the necessary referrals/authorizations, I will be responsible for the full cost of the visit.
4. Verify that Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine is in-network with my specific insurance plan(s). If I neglect to do so and it is later determined Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine is out of network, I am responsible for the full cost of the visit.
5. Inform the office if the patient's need for medical services is due to a motor vehicle, worker's compensation, or other accident and provide necessary claim information.

Your signature below indicates:

1. *You understand and accept our policy of assignment of insurance benefits.*
2. *You attest to the accuracy and completeness of your medical insurance coverage information.*
3. *You authorize this office to release medical information necessary to process your claims and appeals.*
4. *You authorize payment of medical benefits to Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine.*

_____ _____

Signature (Patient or Responsible Party) Date

_____

Printed Name

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CREDIT AND PAYMENT POLICY

Our credit and collection policies are necessary to assure the financial resources needed to maintain this medical office for our patients and the community. We do not want financial circumstances to limit our care for you. If an unusual situation should make it impossible to meet our payment terms, please discuss the matter with our billing department. Please do not avoid the situation. Keep your account and credit in good standing! Our charges are based on costs, time and skill required to provide medical care for you.

Regardless of any insurance coverage, the patient (or guarantor) is ultimately responsible for payment. Self-Pay patients are expected to pay for services at time of service.

If we are contracted with your insurance as an in-network (participating) provider, your percentage of fees are based on your plan's fee schedule, which we have agreed to. We do apply appropriate write-offs to your account per this contracted fee schedule.

If we are not contracted with your insurance as a participating provider, any payments by your insurance are based on your out-of-network benefits. Amounts higher than what they may refer to as *usual, reasonable, or customary,* does not change your portion. As an out-of-network provider, we do not apply any contractual write-offs to your balance.

1. Office visit co-pays and fees for non-covered benefits (including medical supplies/equipment) are due at the time of service.
2. We will send you a billing statement reflecting your balance due, which is your financial responsibility. Payment is due within 30 days of the statement date.
3. If your insurance has not remitted payment after 45 days of a claim submission, you will be expected to begin payments. Any payment received by our practice from your insurance after you have made payments that results in a credit balance on your account, will be refunded to you.
4. If you are late and your appointment must be rescheduled, fail to show for an appointment or if you cancel with less than 24-hour notice given, you may be responsible for an associated fee of $50.00.
5. **A service charge of $5.00 will be applied to account balances requiring a second billing statement if the balance is outstanding after the 30-day payment requirement. This $5.00 service charge will be applied to any subsequent billing statements.**
6. There is a $20 fee for checks returned to the practice due to insufficient funds.
7. Accounts 90 days past due are referred to a professional collection agency. Services provided to you by this clinic will be suspended until the past due balance is paid in full.
8. If it becomes necessary to forward account to collections, I agree to pay any attorney fees.
9. Dr. Hecker's goal is to stay affordable to the community that he serves, so he needed to implement a fee. Our office has made a cash discount included in all pricing, therefore, ALL transactions made with a **MAJOR CREDIT CARD** will receive a 3.5% fee that will be applied and shown on the card transaction receipt.
   Please note this change is for payment by **MAJOR CREDIT CARDS** only. Debit cards, Flexible Spending Accounts (FSA) and Health Reimbursement accounts (HRA) cards are exempt from the fee.
   You will still have the option to pay by check, cash or debit card without any additional fees.

Your signature below indicates you have read and understand the credit and payment policy of Hecker Sports Medicine LLC, DBA Hecker Sports and Regenerative Medicine.

_____ _____

Signature (Patient or Responsible Party) Date

Printed Name: _____

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CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Hecker Sports Medicine, LLC to provide medical care and/or administer diagnostic and/or therapeutic procedures and treatments per the decision of the healthcare provider or certified athletic trainer in attendance which are deemed medically necessary and advisable. It is my responsibility to make known all contraindication to care I may have, and I assume all responsibility/liability if I do not report my past medical history, illness, medicines, allergies, or any health issues that may interfere with my care.

I understand that Hecker Sports Medicine, LLC does not provide care for any medical conditions other than those addressed by my treatment plan. I acknowledge that they do not prescribe nor refill ANY controlled substances and will only prescribe medications that are deemed medically necessary.

Furthermore, I do not expect Dr. Hecker or the Certified Athletic Trainer to be able to anticipate all risk and complications associated with the kind of medical care being provided and wish to rely upon them to exercise their best judgment during said course of care. This includes the history and physical exam, any diagnostic test ordered, and any procedures deemed necessary and in my best interest. I have had the opportunity to discuss the nature, purpose and risk of medical treatment and procedures provided by Hecker Sports Medicine, LLC and have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation for medical treatment and have been informed and weighed the risk involved in such care at this office. I have decided that it is in my best interest to receive care provided by Hecker Sports Medicine, LLC and hereby give my consent to that treatment. I understand that this consent will cover the entire course of treatment for my present condition(s) and for any future conditions for which I seek treatment. I also understand that a procedure consent form will be signed on the day of every procedure and further risk may be discussed as necessary at that time. If there is any dispute about my care, I agree to resolution by binding arbitration to the American Arbitration guidelines and current malpractice terms.

The below signature signifies my understanding of this consent and agreement to the above.

_____ _____/_____/_____

Printed Name of Patient Date

_____ _____/_____/_____

Signature of Patient or Representative Date

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Durable Medical Equipment (DME) Agreement

Thank you for choosing Hecker Sports and Regenerative Medicine for your care! We are committed to the success of your medical treatment.

We dispense various durable medical equipment items in office that are not billed to insurance. You may or may not receive any items during your visit. By signing this form, you acknowledge that all sales are final and items are non-returnable and non-refundable in the event you receive any durable medical equipment.

I have read, understand the above DME agreement. I understand that the items I have received are not being billed to my insurance and I am responsible for the cost.

_____ _____ _____

Patient Name Signature of Responsible Party Date

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PATIENT REFERRAL SOURCE

Dear New Patient,

We are interested in tracking our referral sources. If you would, please take a moment to complete this form and return it to the receptionist.

We look forward to helping you and your family with your medical needs. Thank you.

How did you hear about our practice? (please check all that apply)

- ☐ Saw Dr. Hecker at OCR
- ☐ Physician/Provider: *Doctor's name*: _____ *Facility*: _____
- ☐ Insurance Company: _____
- ☐ Friend or Family Member: _____
- ☐ Internet / Web Search
- ☐ Radio
- ☐ Other – Please List: _____

PATIENT NAME: _____ DATE:_____

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Appointment Times

PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

Your time is valuable to us. Please be aware that Dr. Hecker sees complex cases that can put us behind schedule. He will make sure to spend the appropriate amount of time answering all your questions. Please have your questions/concerns written down ahead of time, as this will allow us to keep appointments relevant, concise and on time.

If you are more than **five minutes** late for your appointment or therapy session, you may be asked to reschedule.

Please notify us of any cancellations at least 24 hours before your appointment. Failure to notify us in time or failure to show up to the appointment could result in a $50 charge.

If you need to cancel your appointment after clinic hours, please leave a message for the front desk.

Cancellation messages left 24 hours before your appointment will NOT incur a $50 charge.

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INSURANCE NOTICE:

PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

We are **NOT** in network with the following insurance plans:

Medicaid

(We are unable to see patients with Medicaid as a Primary, Secondary or Tertiary. We are also unable to see Medicaid patients as self-pay)

Aetna – Colorado Front Range

Aetna- Health Network Only Open Access

Anthem/Blue Cross – Pathways Network

Anthem/Blue Cross – Woodward Network

Anthem/Blue Cross – CU Exclusive 1 & 2 HMO

Anthem/Blue Cross- Blue Priority HMO

Anthem/Blue Cross- MediBlue/Dual HMO

Cigna -Colorado Connect

Kaiser Insurance

We cannot guarantee we are in network with any insurance plan. It is the patient's responsibility to verify coverage and obtain any necessary referrals prior to your appointment.