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

PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS: **DATE:**_________________

First Name:_________________________ MI:__________________Last:_____________________. DOB:________________.

Mailing Address:_______________________________________City:__________________State:_________Zip:_________

Phone (home)____________________________(cell)____________________________(work)_______________________

Email:____Employer:____

Emergency Contact:__________________________Phone:________________________Relationship:________________

Primary Care Doctor :____Phone:_____________________

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 *Cyton Laser* *Tecar* *Prolotherapy* *Sanexas* *Vissman* *Normatec*

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.

____

____

____

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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 notice of privacy practices.

CONSENT TO TREAT

I authorize Hecker Sports Medicine LLC 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 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 parents: ____________________________________
- [ ] 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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FINANCIAL POLICY

Thank you for choosing Hecker Sports Medicine LLC. 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.

We are a private pay practice. We do not bill insurance or Medicare. Ultimately, the patient is responsible for payment and PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

1. We can provide documentation for the patient to self-submit to their insurance for possible reimbursement; however, we do not guarantee any reimbursement. Furthermore, we are not a mediator between you and your insurance company and will not enter into any dispute with them. If you have Medicare Part B, there is no reimbursement.
2. You may or may not receive any durable medical equipment (DME) during your visit. By signing this form, you acknowledge that all sales are final, and items are non-returnable and non-refundable.
3. For an outstanding balance, we will send you a billing statement reflecting the amount due, which is your financial responsibility. Payment is due within 30 days of the statement date.
4. If you are late and your appointment must be rescheduled, fail to show up 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.

Your signature below indicates you have read and understand the financial policy of Hecker Sports Medicine LLC.

____ _________________________

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, Annemarie Hofmeister, NP 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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NON-PARTICIPATING PROVIDER

I acknowledge that Hecker Sports Medicine LLC is not a participating provider and is not in-network with my health insurance plan and will not bill my insurance company for any services or supplies I receive.

Therefore, I understand that I am responsible to pay at the time of service for all services I receive from Hecker Sports Medicine LLC.

____

Printed Patient Name

____

Patient Signature

____

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:______________________

<u>Appointment Times</u>

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 <u>NOT</u> incur a $50 charge.