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 (REQUIRED):____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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NEW PATIENT INTAKE FORM

THOMAS HECKER DPM

Name: ____Date: _______________________________

Shoe Size:______________

Local Pharmacy: ____

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/Laser treatments *Amniotic Stem Cell Injection* *Prolotherapy*

Other Alternative Treatments:____

Ongoing Medical Problems:

____

____

Allergies:

____

____

Current Medications:

What medications are you currently taking? Please include over the counter and supplements. Include strength if known.

____

____

____

Patient Name: ____ Date: ___________________________

Past Surgical History:

____

____

____

Family History/Major Illness:

____

____

Social History:

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

****For Clinic Use Only******

Imaging Done in clinic 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 Institute PLLC, DBA Hecker Sports and Regenerative Medicine, notice of privacy practices.

CONSENT TO TREAT

I authorize Hecker Institute PLLC, 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 Institute PLLC, 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 Institute PLLC, 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-payment 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 Institute PLLC, 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 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 Institute PLLC, DBA Hecker Sports and Regenerative Medicine.*

____ ________________________

Signature (Patient or Responsible Party) Date

____

Printed Name

Sports and Regenerative Medicine
HECKER

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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. Transactions made with a credit or debit card will receive a 3.5% non-cash adjustment in fees that will be applied and shown on the card transaction receipt. This DOES NOT apply to Flexible Spending Account (FSA), Health Savings Accounts (HSA) or Health Reimbursement Account (HRA) cards. Fees paid by cash, check, FSA, HSA or HRA cards are set to include a cash discount.

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

_______________________________________ _______________________

Signature (Patient or Responsible Party) Date

Printed Name: ______________________________

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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:_____________________

Sports and Regenerative Medicine
HECKER

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.

Also, please note that we will reschedule your appointment if you are more than **ten minutes** late for an appointment with Dr. Hecker.

If you are more than **five minutes** late for a Piezo/Laser therapy session, **we may have to shorten your therapy session or 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.

____

INSURANCE NOTICE:

PLEASE RETAIN THIS PAGE FOR YOUR INFORMATION

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

Aetna – Colorado Front Range

Aetna- Health Network Only Open Access

Anthem/Blue Cross – Pathways Network

Anthem/Blue Cross – CU Exclusive 1 & 2 HMO

Anthem/Blue Cross- Blue Priority HMO

Anthem/Blue Cross- MediBlue HMO

Anthem/Blue Cross- MediBlue Dual HMO

Cigna – Local Plus Network

Kaiser Insurance

Medicaid

Tricare Prime

VA- ALL Plans

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 appointments.

01/18/2019