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

PATIENT INTAKE FORM

PATIENT DEMOGRAPHICS: **DATE:**_____
(MM/DD/YYYY)

First Name:_____MI:_____Last:_____DOB:_____
(MM/DD/YYYY)

Mailing Address:_____City:_____State:_____Zip:_____

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

Email:_____

Emergency Contact:_____Phone:_____Relationship:_____

Preferred Appointment Reminder Type: Phone: [ ] Text: [ ] Email: [ ]

Responsible Party: First Name:_____ MI:_____Last:_____. DOB:_____
(MM/DD/YYYY)

Mailing Address:_____City:_____State:_____Zip:_____

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

Email:_____

Primary Care Doctor :_____Phone:_____

Shoe Size:_____

Local Pharmacy: _____ Address:_____

Reason for visit:_____

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

Allergies:

Past Surgical History:

Family History/Major Illness:

Social History		**What Kind**	**Frequency**
Do you use Tobacco?	Y / N		
Do you drink alcohol?	Y / N		
Do you use recreational drugs?	Y / N		
Do you use marijuana?	Y / N		

PATIENT NAME:_____ RESPONSIBLE PARTY:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered or provided a copy of Hecker Sports Medicine LLC Notice of Privacy Practices.

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 in writing by the patient or his/her legal representative.

If an option is not indicated in the above section, Hecker Sports Medicine LLC will default to HIPAA guidelines and not release information to anyone

Your signature below indicates that you have read and understand the Hecker Sports Medicine LLC Notice of Privacy Practices document.

_____ _____
Signature (Patient or Responsible Party) Date (MM/DD/YYYY)

Printed Name: _____

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FINANCIAL RESPONSIBILITY

Thank you for choosing Hecker Sports Medicine LLC. Our credit and collection policies are necessary to assure the financial resources needed to maintain this 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 for you 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 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. **All of our treatments are self-pay and are not billable to insurance. There are no insurance CPT codes that correspond to these services. Treatments and medical services are non-refundable.**
2. **NOTICE TO CUSTOMERS PAYING WITH CREDIT CARD EFFECTIVE April 8, 2024:**
   We impose a surcharge of 3% when paying with a credit card, which is not greater than our cost of acceptance. The adjustment will appear on your receipt. This surcharge does not apply to debit/ HSA/ FSA cards. Any purchases made with a debit/HSA/FSA card or cash will NOT include a surcharge.
3. You may or may not receive durable medical equipment (DME) during your visit. Should DME be recommended, you acknowledge that all sales are final, and items are non-returnable and non-refundable.
4. 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.
5. If you are late and your appointment must be rescheduled, if you fail to show up for an appointment, or if you cancel with less than a 24-hour prior notice, you will be responsible for a fee of $50.00 (a no-show fee).
6. **New patient appointments are scheduled for 30 minutes and priced at $100. If your initial consultation exceeds 45 minutes, you will be charged $300 for the full hour.**
7. **New patient Regenerative Consults are scheduled for 60 minutes and priced at $400.**
8. **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.**
9. There is a $30 fee for checks returned to the practice due to insufficient funds.
10. Accounts 90 days past due are referred to a professional collection agency. Also, services provided to you by Hecker Sports Medicine LLC will be suspended until the past due balance is paid in full.
11. If it becomes necessary to forward your account to collections, I agree to pay all fees including 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 (MM/DD/YYYY)

Printed Name: _____

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CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request Hecker Sports Medicine, LLC ("Hecker") to perform diagnostic services and provide a recommended treatment plan, if any, which is deemed medically necessary and advisable. I understand that Hecker does not provide care for any medical conditions other than those addressed by my treatment plan. I acknowledge that Hecker will only prescribe medications that are deemed medically necessary. Nothing stated by Hecker or its representatives should be construed as a diagnosis of an illness or disease. It is my responsibility to make known my past medical history, illness, medicines, allergies and any health issues. I understand the importance of informing Hecker or its representatives of any change in my medical condition and of any pain or discomfort from the treatments.

I do not expect Hecker to be able to anticipate all risk and complications associated with the kind of care being provided under the treatment plan and I wish to rely upon Hecker or its representatives to exercise their best judgement during the application of the therapeutic treatments of the treatment plan. I have had the opportunity to discuss the nature, purpose and risk of the therapeutic treatments that will be provided by Hecker and have had my questions answered to my satisfaction. I understand that specific results are not guaranteed. I also understand that Hecker, its representatives, or I may terminate any treatment session at any time. I will not hold Hecker or its representative liable for any pain or discomfort during or after the treatment sessions.

I have decided that it is in my best interest to receive care provided by Hecker and hereby give my consent to 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. My consent for treatment is informed and voluntary and I understand that I may withdraw it at any time except for treatment that I have already consented and received.

By signing this form, I understand I am consenting to treatment as outlined herein and release Hecker and its representatives from all liability for any pain, discomfort, or any other issues or consequences that may result from any treatments.

_____ _____

Printed Name of Patient Date (MM/DD/YYYY)

_____

Signature of Patient or Representative

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EMAIL COMMUNICATION CONSENT

Email may be utilized for documentation purposes as well as for further communication between Hecker Sports Medicine LLC and its patients. Emails may include but are not limited to treatment plans and pricing, appointment information, superbills, receipts, reviews, marketing, and office closures.

Patients should not use email to communicate with Hecker Sports Medicine LLC in an emergency or if immediate attention is required.

This authorization grants Hecker Sports Medicine LLC the use of email to communicate with patients and/or their responsible party(s). By agreeing to use this form of communication, you understand and acknowledge the risks involved, and give your consent to the use of email communications. You also acknowledge and understand your decision to utilize email is strictly voluntary, and that consent may be withdrawn at any time in writing.

Please initial below:

_____ Yes, I consent to email communication with Hecker Sports Medicine.

_____ No, I do not consent to email communication with Hecker Sports Medicine.

_____ _____

Printed Name of Patient Date (MM/DD/YYYY)

_____

Signature of Patient or Representative

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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 first hear about our practice?

- ☐ I am a prior patient of Hecker Sports Medicine
- ☐ My Physician/Provider: *Doctor's name*: _____ *Facility*: _____
- ☐ My Friend or Family Member: _____
- ☐ Google/Bing/Web Search: _____
- ☐ Social Media (Instagram/Facebook): _____
- ☐ Other – Please List: _____

PATIENT NAME: _____ DATE:_____
(MM/DD/YYYY)

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.