

Jeffrey W. Heitkamp, M.D.
Diplomate, American Board of Neurological Surgery

PATIENT INFORMATION

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____
STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
SEX _____ BIRTHDATE _____ AGE _____ SSN _____
HOME# _____ WORK# _____ CELL# _____
REFERRING DOCTOR / PCP _____ SMOKER: YES ___ NO ___
EMPLOYMENT STATUS: FULL-TIME ___ PART-TIME ___ NOT EMPLOYED ___ SELF EMPLOYED ___
RETIRED ___ ACTIVE DUTY _____
SINGLE - MARRIED - DIVORCED - WIDOWED _____ IS THIS A WORK INJURY: YES ___ NO ___
CIRCLE ONE IS THIS AN AUTO ACCIDENT: YES ___ NO ___
STUDENT STATUS: FULL-TIME _____ PART-TIME _____ MEDICATION ALLERGIES: _____
DRIVERS LICENSE #: _____
EMERGENCY CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____
PHONE# _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICYHOLDER _____
POLICYHOLDER'S SEX ___ POLICYHOLDER'S DOB _____ POLICYHOLDER'S SSN _____
PATIENT'S RELATIONSHIP TO POLICYHOLDER _____ POLICY EFFECTIVE DATE _____
POLICYHOLDER'S EMPLOYER _____ PATIENT'S POLICY ID _____
EMPLOYER'S ADDRESS _____ GROUP # _____
CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE _____ POLICYHOLDER _____
POLICYHOLDER'S SEX ___ POLICYHOLDER'S DOB _____ POLICYHOLDER'S SSN _____
PATIENT'S RELATIONSHIP TO POLICYHOLDER _____ POLICY EFFECTIVE DATE _____
POLICYHOLDER'S EMPLOYER _____ PATIENT'S POLICY ID _____
EMPLOYER'S ADDRESS _____ GROUP # _____
CITY _____ STATE _____ ZIP _____

PATIENT'S SIGNATURE _____ DATE _____

DATE _____

NAME _____

REASON FOR THIS VISIT (MAIN COMPLAINT): _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

LIST ANY TREATMENT YOU'VE HAD FOR THIS PROBLEM: (P.T., MEDICATION, CHIROPRACTIC, OR INJECTION): _____

LIST ANY PAST SURGERIES: _____

LIST ALL MEDICATION YOU'RE CURRENTLY TAKING, BOTH DOSE & FREQUENCY:

ARE YOU CURRENTLY TAKING ANY DIET OR HERBAL SUPPLEMENTS?

YES ___ NO ___

IF YES, LIST NAME & DOSAGE _____

LIST ANY DRUG ALLERGIES: _____

HEIGHT _____ WEIGHT _____

SMOKE: YES ___ NO ___ IF YES, HOW MUCH _____

DRINK ALCOHOL: YES ___ NO ___

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

ANGINA (CHEST PAIN) _____

ASTHMA _____

BLEEDING DISORDER _____

HEART ARRHYTHMIA _____

CONGESTIVE HEART FAILURE _____

MENINGITIS _____

HYPERTENSION _____

DIABETES _____

CORONARY ARTERY DISEASE _____

HEPATITIS _____

HIV POS. _____

SLEEP APNEA _____

SEIZURES _____

SPINAL SURGERY _____

CANCER _____

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RELEASE OF MEDICAL INFORMATION

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO
PROCESS THIS CLAIM AND RELATED CLAIMS.

SIGNATURE _____

PAYMENT OF MEDICAL BENEFITS

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED
PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED.

SIGNATURE _____

SUPPLIER – ARLINGTON ASSOCIATION OF NEUROLOGICAL SURGEONS, P.A.

Arlington Association of Neurological Surgeons

1001 N. WALDROP, SUITE 801 * ARLINGTON, TX 76012 (817) 274-4593

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE MY PHYSICIAN AND/OR ADMINISTRATIVE AND CLINICAL STAFF TO (CHECK ALL THAT APPLY):
____ USE THE FOLLOWING PROTECTED HEALTH INFORMATION, AND/OR
____ DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION TO {NAME OF ENTITY OR CLASS OF PERSONS TO RECEIVE INFORMATION}:

{SPECIFICALLY AND MEANINGFULLY DESCRIBE THE PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED SUCH AS DATE OF SERVICE, TYPE OF SERVICE, LEVEL OF DETAIL TO BE RELEASED, ORIGIN OF INFORMATION, ETC.}

THIS PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSES:

{LIST SPECIFIC PURPOSES HERE. "AT THE REQUEST OF THE INDIVIDUAL" IS ACCEPTABLE IF THE PATIENT MAKES THE REQUEST, AND THE PATIENT DOES NOT WANT OR STATE A SPECIFIC PURPOSE.}

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL {SPECIFY (1) DATE OR (2) EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE} AT WHICH TIME THIS AUTHORIZATION TO USE OR DISCLOSE THIS PROTECTED HEALTH INFORMATION EXPIRES. ("END OF THE RESEARCH STUDY" AND "NONE" IS ACCEPTABLE FOR AUTHORIZATION FOR RESEARCH PURPOSES.) I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME BY SENDING SUCH WRITTEN NOTIFICATION TO THE PRACTICE'S PRIVACY CONTRACT AT {OFFICE ADDRESS OR E-MAIL ADDRESS.} I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT MY PHYSICIAN HAS RELIED ON THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONTEST A CLAIM.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW. MY PHYSICIAN WILL NOT CONDITION MY TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN OR ELIGIBILITY FOR BENEFITS (IF APPLICABLE) ON WHETHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OR DISCLOSURE EXCEPT (1) IF MY TREATMENT IS RELATED TO RESEARCH, OR (2) HEALTH CARE SERVICES ARE PROVIDED TO ME SOLELY FOR THE PURPOSE OF CREATING PROTECTED HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY.

THE USE OR DISCLOSURE REQUESTED UNDER THIS AUTHORIZATION WILL RESULT IN DIRECT OR INDIRECT REMUNERATION TO MY PHYSICIAN FROM A THIRD PARTY. {IF APPLICABLE BECAUSE THE AUTHORIZATION IS OBTAINED FOR MARKETING PURPOSES.}

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE _____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I CONSENT TO THE USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** FOR THE PURPOSE OF DIAGNOSING OR PROVIDING TREATMENT TO ME, OBTAINING PAYMENT FOR MY HEALTH CARE BILLS OR TO CONDUCT HEALTH CARE OF **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA**. I UNDERSTAND THAT DIAGNOSIS OR TREATMENT OF ME BY **JEFFREY HEITKAMP, MD** 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. **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS THAT I MAY REQUEST. HOWEVER, IF **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** AGREES TO A RESTRICTION THAT I REQUEST, THE RESTRICTION IS BINDING ON **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA AND JEFFREY HEITKAMP, MD**.

I HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT **JEFFREY HEITKAMP, MD OR ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** HAS TAKEN ACTION IN RELIANCE ON THE CONSENT.

MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC 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 **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA'S** NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS DOCUMENT.

THE **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA'S** NOTICE OF PRIVACY PRACTICE HAS BEEN PROVIDED TO ME. THE NOTICE OF PRIVACY PRACTICES DESCRIBES THE TYPE 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 **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** IS ALSO PROVIDED IN THE WAITING ROOM. THIS NOTICE OF PRIVACY PRACTICES ALSO DESCRIBES MY RIGHTS AND THE **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION.

ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I MAY OBTAIN A REVISED NOTICE OF PRIVACY PRACTICES BY ACCESSING THE **ARLINGTON ASSOC. OF NEUROLOGICAL SURGEONS, PA** WEBSITE, CALLING THE OFFICE AND REQUESTING A REVISED COPY TO BE SENT IN THE MAIL OR ASKING FOR ONE AT THE TIME OF MY NEXT APPOINTMENT.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT FOR PATIENT

DATE _____