Dennis R. Gutzman, MDPA

Certified by the American Board of Orthopaedic Surgeons

Patient Information
PLEASE PRINT

Today's Date: ________________

Information is needed in order to comply with federal guidelines. Please fill out all information. If it does not apply to you, please put N/A. This information will be used for the purpose of carrying out treatment, payment and health care operations.

Patient's Name: ____ Age_______ Date of Birth : ______________ Male ____ Female____

Home Address: ____________________________________ City__________________________ State_________ Zip_________

Home Phone____________________ Cell # ______________________ Social Security #__________________________________

Email Address: ____

Patients Drivers License/ID # ________________________________ If other than Texas, What State? ___________

Patient's Employer: ____ Employers Phone Number ___________________________

Address: ____________________________________ City ____________________________ State __________ Zip___________

Patient's Occupation: ____________________________ Are you: Single ____ Married ____ Divorced _____ Spouse Deceased_____

Spouse's Name: _____________________________ Social Security Number __________________ Spouse Work#________________

If Patient is a child, Parent/Guardian Name: ____ SSN: _____________________

Employer:________________________ Work Phone Number: __________________ Cell ________________ Home#______________

Injury/Illness: Auto Accident ____ Work Related Injury ____ Injury at Home____ No Injury____ Other ______________________

Date of INJURY/ ACCIDENT: ______________ If not injury Date of onset of pain ___________

We will require a copy of your health insurance card and/or your Drivers License/ID card.

Per Texas Senate Bill 418, a physician has 90 days from the date of services to file a claim with your insurance company. If a claim is not filed within that time frame, your insurance carrier can/will deny payment for your medical bills in our office.

If you do not have an insurance for us to file please sign now:

I HAVE NO INSURANCE FOR DR. GUTZMAN TO FILE: ____ ___________

(Patient/Parent/Guardian signature) Today's Date

Primary Insurance Name of Insurance Carrier ____

Address____ Phone Number ______________________________________

Insured: _________________________ Date of Birth: _________ Relationship to Patient: Self - Spouse – Child

Effective date of insurance __________________ Other: ____________________

ID# _______________________________ Group Number____________________________

Secondary Insurance: Name of Insurance Carrier ____

Address________________________________ Phone #____

Insured: ____________________________ Date of Birth: _________ Relationship to Patient: Self Spouse Child Other______________

ID# _______________________________ Group Number____________________________

Effective Date of Insurance:________________________

All information provided is correct and true to the best of my ability ____ ___________

Patient/Parent/Guardian Signature **Today's Date**

Dennis R. Gutzman, MDPA

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Release of Information

Unless you give written permission we will not release your medical information according to the HIPPA guidelines.

Patients Name: ________________________________ Date of Birth ____________

Who do you want us to contact in case of an Emergency:

Name: _________________________Phone ________________ How Related ____________________

If you have someone who you want us to release medical information to such as a Spouse, Child, or Parent please list below.

Name _________________________________ Relationship to You ________________________

Name_________________________________ Relationship to You________________________

"I give permission for the above person(s) to receive my medical information".
This Authorization is good for one year.

____ ________________
Patient's/Guardian's Signature Today's Date

Your referring physician will have a report faxed to their office.

If you have an Attorney on this case that we need to release information to please fill out the following.

Attorney ___________________________ Phone: ________________ Fax:________________

Patient's Signature_________________________________

Date: __________ (*Authorization Good for 1 year from date signed*)

WORK STATUS

Are you working? _____ Disabled?_______ Retired? ______ Homemaker ________ Minor patient: _____
If you are working, have you lost time from your job due to the pain you are experiencing?______________
Are you having problems with any requirements of your job or activities of daily living due to the pain you are experiencing? ______
If so, what are the requirements/activities that make it difficult for you?_________________________
____

This is acknowledgement that you received our Notice of our Privacy Practices required by law to maintain the privacy of our patients with respect to protected health information.

____
Signature of the Patient/Guardian

PATIENT MEDICAL QUESTIONAIRE **Motor Vehicle Accident**

Please Print

Patient's Name: ________________________________Date of Birth______________ SSN:_____________________________

Date of Accident: ___________________________

***** PLEASE FILL OUT ALL QUESTIONS. IF IT DOES NOT APPLY TO YOU PLEASE MARK N/A OR NO.*****

How did the accident/injury happen? Also, please give street, city, state, intersection, weather conditions, etc. Please be specific.

____

____

Were you the **driver** ______ Front Seat **Passenger** ______ Back seat **passenger** _____ Other:_______________________________

Were you wearing a seat belt at the time of the accident? Yes _______ No _______

What part of the body did you injured? (Please specify right or left).

____

What is your Chief Complaint today?

____

If you are having **neck or back pain** are you, or have you had, any bowel or bladder problems? Yes or No

Have you been treated for this injury? _______ If so, by whom? (list all Doctors, Hospital ER, etc.)______________

____

What type of treatment have you had for this injury? Please indicate what facility and the date.

X-rays ____ MRI ______________________________________

Cat Scan ______________________________________ Discogram __________________________________

Bone Scan _____________________________________ Myelogram __________________________________

Physical Therapy ________________________________

How many weeks/months of therapy have you had for this injury? Days _____ Weeks, ______ Months ____

EMG testing: ____________Epidural Steroid Injections: _________ Pain Management program: _______________

Have you had surgery for this injury or problem? If yes, when was the surgery and for what part of the body?

____

Who did your surgery and where was it done at:

____

Any Other treatment not listed above:

____

List medications you are taking for this injury?

____

____

PAST MEDICAL/SOCIAL/FAMILY HISTORY

Patient's Name: ____________________________________ Date of Birth _______SSN:__________________

Have you ever had the same or similar problems in the past? _________. If so, when? ________________________
Do you use Tobacco products: Yes ____ No _____
Do you drink Alcohol: Yes ____ No _____ Occasionally _____ Socially _____
Are you Allergic to any Medications: Yes___No ____
Please list the medications you are allergic to : ____

____

Please check off whether you have had or your family has had any of these types of illnesses:

	Self	Which family member has/had this illness: Father	Mother	Brother	Sister	Controlled	Treatment
High Blood Pressure	____	_____	______	_____	_____	______	_____
Diabetes	____	_____	______	_____	_____	______	_____
Heart Disease	____	_____	______	_____	_____	______	_____
Lung Disease	____	_____	______	_____	_____	______	_____
Kidney Disease	____	_____	______	_____	_____	______	_____
Liver Disease	____	_____	______	_____	_____	______	_____
Intestinal Disease	____	_____	______	_____	_____	______	_____
Seizures	____	_____	______	_____	_____	______	_____
Hepatitis	____	_____	______	_____	_____	______	_____
Stroke	____	_____	______	_____	_____	______	_____

Explanation of any illness above or other illness not mentioned:

____

Your Past Surgical History (Operations)

1) ____ Year _______

2) ____Year_______

3) ____Year _______

4) ____Year _______

Check off any of the following if you have had within the past 6 months.

Muscoloskeletal : Joint pain/Stiffness ___, Weakness ___
Nervous System: Nervousness ___, Numbness ____, Paralysis ____, Dizziness____, Convulsions ___ ,Epilepsy ____,
Cold/Tingling extremities ___
Respiratory: Shortness of Breath ____ Pneumonia ____, Influenza ___, Tuberculosis ____ Pleurisy ____,Whooping Cough ____
Cardiovascular System: Chest Pain ___, Rheumatic Fever ____
General: Fatigue ___, Fever ___, Headaches ___, Allergies ____, Difficulty Sleeping ___, Forgetfulness ____, Confusion ___,
Gastrointestinal: Black/bloody stools ___, abdominal cramps ___
Genitourinary: Bladder trouble ___, Painful/Excessive Urination ___, Discolored urine____, Difficulty urinating ____
EENT System: Vision Problems ___ Dental Problems ___, Sore throat ___, Hearing problems ___ Difficulty swallowing ___, Heartburn ___
Hematologic/Lymphatic/Immunologic: Anemia ___, HIV/AIDS ____, Clotting problems ____, Thyroid Disorder ___,
Lymphatic disorders ___
Skin: Discoloration ___, skin cancer ____, Skin grafts,

Patient Signature: ____________________________________ Today's Date ____________________________

HIPAA Notice of Privacy Practices

Dennis R. Gutzman, M.D.P.A.
2424 Babcock Rd., Ste 201
San Antonio, TX 78229
210-616-0462/ fax: 210-616-0467

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by Dr. Gutzman, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of Dr. Gutzman's practice, and any other use required by law.

Workers Compensation:
Texas state law requires, and the federal law allows, use and disclosure of private health information (PHI) to the Commission, worker's compensation insurers, employers, or other entities involved in the administration of worker's compensation benefits without an authorization.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of Dr. Gutzman's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when Dr. Gutzman is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures **Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that Dr. Gutzman or his practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Dr. Gutzman is not required to agree to a restriction that you may request. If he believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have Dr. Gutzman amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This request should be legibly written and submitted to our office. We will mail this information to you within 30 days from receipt of the request as the law allows.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

Dennis R. Gutzman, MDPA
Certified by the American Board of Orthopaedic Surgeons
2424 Babcock Rd., Ste 201
San Antonio, TX 78229
210-616-0462/ f:210-616-0467

Assignment of Benefits

In order to facilitate the ability of the Office of Dr. Dennis Gutzman to collect its charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Office's services agree to the following and direct all Payers as follows:

I authorize and direct Dr. Gutzman's Office to submit my charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my charges are submitted to more than one payer, I hereby authorize and direct the Office to apply any proceeds received from a Payer to my charges.

I also agree to and understand that it is my responsibility to inform Dr. Gutzman's Office of any changes to my insurance coverage in order for the office to comply with Texas Department of Insurance Regulations.

I am also acknowledging that I received Dr. Gutzman's Notice of our Privacy Practices required by law to maintain the privacy of our patients with respect to protected health information.

____

Patient's Name Date of Birth SSN

____

Patient's/Guardian Signature Today's Date

DENNIS R. GUTZMAN, MDPA
FINANCIAL POLICY

Thank you for selecting Dr Dennis Gutzman as your healthcare provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician. Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check, VISA, MasterCard and American Express.

1. Your insurance policy is a contract between you, your employer and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges."

   We are, however, contracted with most managed care plans. Please present your insurance card at the front desk so that we can file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual provider discounts will be deducted from your balance.

2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies and some employers decide what a covered benefit is and what is not. Please check your insurance plan document for any questions. Fees for these services along with unmet deductibles and co-payments are due at the time of treatment.

3. Co-Payments not paid at the time of service are subject to a $10 processing fee. All balances more than 60 days past due are subject to a penalty of $10 per month to cover the cost of sending additional statements.

4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay within 60 days, you will be responsible for payment.

5. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party.

6. Please note that all cancellations for scheduled appointments must be made at least 24 hours in advance, which allows us to care for other patients in need of our services. If you fail to cancel your appointment, you may be charged a $25 service fee which will not be covered by your insurance plan.

7. There will be a $25 NSF charge on all returned checks.

8. Occasionally an insurance payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. You may request a refund of overpayment by notifying the Office Manager.

9. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to our Office Manager, so that we can assist you in management of your account with a payment plan.

   I give permission to Dr. Dennis Gutzman to convert any paper check or check by phone to an electronic transaction.

   Again, thank you for choosing Dr. Dennis Gutzman. We appreciate the opportunity to serve you.

Patient / Guardian Signature:________________________________ Date:_____________

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration: In order to facilitate the ability of the Office to collect its charges directly from various Payors and thereby to enhance the patient–provider relationship, I, the undersigned, as consideration for the Office's services agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office and further grant a contractual lien to the Office **with respect to my charges.** I understand that these assignments of rights and contractual lien may effectuate, automatically or other wise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the Secretary of State or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms. I understand that I remain personally responsible for my Charges. Consistent with law or contact, I agree to pay the full amount of my Charges to the Office upon their demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment–in–full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my Charges.

In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the office hereby requests) each attorney to provide immediate notice to the Office regarding any proceeds received by the attorney(s), to promptly pay the Office in full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write–offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse, or my dependents. I further authorize the Office to apply any credit balance on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non–conveniens.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Definitions. For the purpose of this Agreement, the following terms shall have the following meaning: **"Office" shall refer to Dr.Dennis Gutzman** located at 2424 Babcock Rd., Ste 201, San Antonio, TX 78229; **"Payer"** shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at–fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; **"Proceeds"** shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, Worker's Compensation, disability, and malpractice; **"Charges"** shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), and Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; **"Collection Costs"** shall include, without limit, and pre– and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Patient Name (please print)______________________________ **Date of Birth**________________

Patient's Signature:______________________________ **Date:**___/___/____ **SSN:**________________

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (Please Print)____________________

Parent/Guardian Signature:______________________________ **Date:** ___/___/____