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 # _____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**

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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?_____

_____

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 _____

PATIENT MEDICAL QUESTIONAIRE **Other Than MVA**

Please Print

Patient's Name: _____Date of Birth_____SSN:_____

Date of injury/Onset of illness: _____

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

What is your chief complaint today? Please specify right or left side.

_____

_____

If due to an accident or injury please describe how it happened:

_____

_____

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 problem? _____ If so, by whom? (list all Doctors, Hospital ER, etc.) _____

_____

_____

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

X-rays _____ MRI _____

Cat Scan _____ Discogram _____

Bone Scan _____ Myelogram _____

Physical Therapy _____

If you have had physical therapy, how much therapy have you had for this problem? 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 done and what part of the body?

_____

Who did your surgery and where was it done at:

_____

Any Other treatment not listed above:

_____

Please list medications you are taking.

_____

_____

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.**

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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:_____