Robert A. Hein, M.D.

14024 Quail Pointe Drive, Oklahoma City, OK 73134
405.286.4333 Office 405.607.2346 Fax

Patient's Name_____
Last First Middle

Address_____
Street & Apt # City State Zip

Home Phone_____ Cell Phone_____ Work Phone_____

Any restrictions for contacting you? _____ E-mail_____

Contact restrictions_____

Age_____ Birthdate____/____/____ SS# ____-____-____Sex ◇ Female ◇ Male

Marital Status ◇ Single ◇ Married to: _____ Other: _____

Patient's Employer _____ Occupation_____

Address_____

Is it ok to call you at work?_____

Emergency Contact_____ Relationship to Patient_____

Home Phone_____ Other Phone _____

Address_____

Who May We Thank For Referring You? _____

Primary Health Insurance Company _____

Policy #_____Group #_____Ins. Phone_____

Referral Required? ◇ No ◇ Yes Copay? ◇ No ◇ Yes $_____

Insured: Name _____ DOB _____ Employer_____

BENEFITS TO PHYSICIAN: I hereby authorize payments directly to the physician for surgical and/or medical benefits.
RELEASE OF INFORMATION: I hereby authorize release of information for insurance claim purposes.
PHOTOGRAPHS: I hereby authorize that photographs be taken for my medical record.
I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request for this information.

Signature _____ Date _____

Reason for your visit today?_____
Primary Physician's name:_____
Address:_____Phone:_____
Date of last visit:_____Date of last physical:_____

Health History

Age_____ Height_____ Weight_____.

Do you presently have or have you experienced the following:

Y N Heart Disease / Trouble
Y N Chest pain
Y N Abnormal EKG
Y N Congestive heart failure
Y N Pacemaker/ Defibrillator
Y N High blood pressure
Y N Swelling of ankles or feet
Y N Stroke
Y N Frequent headaches/ migraines
Y N Rheumatic fever
Y N Pulmonary disease/ COPD
Y N Asthma/ Difficulty breathing
Y N Tuberculosis
Y N Sleep apnea/ C-PAP
Y N Home oxygen
Y N Chronic cough/ Emphysema
Y N Sinus problems/ Allergies
Y N Diabetes Insulin dependent? Y N
Y N Kidney disease/ Dialysis
Y N Bladder problems
Y N Abnormal bleeding/ Blood thinners
Y N Anemia
Y N Hepatitis: A B C / Jaundice
Y N HIV/ AIDS
Y N Sickle cell disease
Y N Seizures/ Epilepsy
Y N MRSA or other unusual infection

Y N Blood clot/ Deep Vein Thrombosis
Y N Muscle weakness
Y N Arthritis
Y N Joint replacement
Y N Back / Neck trouble
Y N Lupus
Y N Cancer Location_____
Y N Chemotherapy Dates_____
Y N Radiation Dates_____
Y N Hyperthyroid/ hypothyroidism
Y N Liver problems
Y N Scarlet fever
Y N Gastric problems
Y N Heart burn /GERD
Y N Motion sickness
Y N Irritable Bowel Syndrome
Y N Colitis/ Ulcers
Y N Shingles/ Fever blisters
Y N Psychiatric problems
Y N Depression
Y N Anxiety
Y N Panic disorder
Y N Substance use
Y N Alcohol use How often_____
Y N Smoker Date quit_____
Y N Tylenol How often_____
Y N Ibuprofen How often_____

Females only
Y N Are you pregnant Pregnancies #_____ Children #_____

Please list all surgeries/procedures you have had in the past and date:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you have any allergies to Medications, Foods or Environments? Y N
Please list: _____

Medications: List all medication, including non-prescription, you are currently taking.

Name	Dose	How Often	Name	Dose	How Often

Family History **Follow the lines across the page and mark the appropriate box.**

	Alive & Well	Deceased	Cause of Death Age at Death	High Blood Pressure	Heart Disease	Epilepsy	Diabetes	Cancer	Asthma	Tuberculosis	Arthritis	Kidney	Glaucoma	Stroke/Embolism	Migraine	Mental	Anemia
Father																	
Mother																	
Bros/Sis																	
Bros/Sis																	
Bros/Sis																	

Please Note: It is mandatory for patients who do smoke to quit Smoking TWO WEEKS before surgery and a minimum of TWO WEEKS after the procedure. IF YOU THINK THAT YOU CAN NOT REFRAIN FROM SMOKING THIS LONG, PLEASE TELL US!!!!!!

Yes, I can refrain from smoking _____ **No, I cannot** _____
Patient Signature _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. Dr. Hein and his staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This statement of Financial Policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the New Patient Information Forms before seeing the physician.

Regarding Insurance:

The balance on your account is still your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 90 days from the dare services are rendered; the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the services provided by the physician or nurse may be non-covered services and not considered reasonable and necessary under your medical insurance.
Due to recent problems with insurance coverage, you must inform us if your insurance situation changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

I have read the above information and agree with the terms of the Financial Policy.

Signature:
_____Date:_____

Notice of Privacy Practices

I have been given a copy of Notice of Privacy Practices

Signature:_____Date:_____

RELEASE OF PROTECTED HEALTH INFORMATION

Please identify the person or persons you authorize your Protected Health Information (oral or recorded information) to be released to by Robert A. Hein, M.D.

This may include your spouse, parents, siblings, children, friend or guardian. Please list below:

NAME **RELATIONSHIP**

_____

_____

_____

_____

_____

_____

Robert A. Hein, M.D. is required to have your permission to leave messages regarding your Protected health Information (test results, instructions, etc.)

Please check the appropriate items:

_____ Yes, Dr. Hein's office may leave a message on my answering machine/voice mail regarding my Protected health Information.

_____ No, Dt. Hein's office my not leave a message on my answering machine/voice mail regarding my protected Health Information.

Signature_____**Date**_____

Notice of Privacy Practices

This notice desctribes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Informaiton

Under federal law, your patient health information is protected and condifential. Patient health information includes information about your symptoms, test results, diagnonis, treatment and related medical informaiotn. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Information

We use your health information for treatment, to obtain payment and for health care operations, administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example: physicians, nurses and other members of your treatment team will record information in your recordd and use to determine the most appropriate course of care. We may also disclosethe information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your perscriptions and to family members assisting with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain record of payments from your health plan.

Healthcare Operations: We will use and disclose your health information to conduct our stardard internal operations, including proper administation of records, evaluation of the quality of treatment and to assess the care and outcome of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives and other health related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required By Law: We may be required by law to report gunshot wound, suspected abuse or neglect or similair injuries and events.

Public Health Activities: As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpeona or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Death: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.

Threat to health or Safety: We may use and disclose information when necessary to prevent a serouis threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Agencies:If you are a member of the Armed Forces we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Research: We may use or disclose information approved for medical research.

Workers Compensation: We may release your health information for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any furthur uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, however, if we do agree we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by,for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to view or obtain a copy of your health information. There may be a fee for this.

Amend Information:If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we amend or correct the existing information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information and to abide by the tems of the notice currently in effect.

We reserve the right to change our policies at any time. In the event we do make changes in our policies, notices and new policies will be posted in the patient waiting area and exam rooms. Patients may also request a copy of the amended policy.

Complaints

If you are concerned that your privacy rights have been violated, you may contact our office immediately. Yo may also submit written complaint to the U.S. Department of Health and Human Services. Our office will provide you with the appropriate information to exercise your complaint.

If you have any questions, requests or complaints, please contact the person listed below.

Sheila Andreatta with the office of Dr. Robert A. Hein
14024 Quail Pointe Drive
Oklahoma City, Oklahoma 73134
405-286-4333

Effective date of this notice 5/1/14