Jonathan Heistein, MD

Patient Information

LEGAL NAME (LAST, FIRST, MI):_____

ADDRESS:_____CITY:_____ST:_____ZIP:_____

BIRTH DATE:_____ AGE:_____ SS#_____MARITAL STATUS: M S D W

HOME PHONE:_____ CELL PHONE/PAGER:_____

WORK PHONE:_____ E-MAIL ADDRESS:_____

IF PATIENT IS MINOR:
NAME OF PARENT/GUARDIAN: _____ DOB: _____

SS# _____

EMPLOYER:_____ OCCUPATION:_____

PHARMACY NAME:_____ PHONE:_____

REFERRED BY:_____ REASON FOR VISIT:_____

PRIMARY CARE PHYSICIAN:_____ PH#:_____

PRIMARY CARE PHYSICIAN'S ADDRESS:_____

NAME OF PRIMARY INSURANCE:_____ POLICYHOLDER'S NAME:_____

POLICYHOLDER'S SS#:_____ POLICYHOLDER'S BIRTH DATE:_____

RELATIONSHIP TO PATIENT:_____ ID #:_____

POLICYHOLDER'S EMPLOYER:_____ GROUP #_____

NAME OF SECONDARY INSURANCE:_____POLICYHOLDER'S NAME:_____

POLICYHOLDER'S SS#:_____ POLICYHOLDER'S BIRTHDATE:_____

RELATIONSHIP TO PATIENT:_____ ID#:_____

POLICYHOLDER'S EMPLOYER:_____ GROUP #:_____

NAME OF TERTIARY INSURANCE:_____POLICYHOLDER'S NAME:_____

POLICYHOLDER'S SS#:_____ POLICYHOLDER'S BIRTHDATE:_____

RELATIONSHIP TO PATIENT:_____ ID#:_____

POLICYHOLDER'S EMPLOYER:_____ GROUP #:_____

Assignment of Benefits/Financial Responsibility

PLEASE READ

I hereby assign, transfer, and authorize all of my rights, title and interest to my medical reimbursement benefits under my insurance policy for services rendered. I authorize the release of medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain in effect until I give written notice revoking said authorization.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any/all professional services rendered. I understand that I am still obligated to paid bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I understand that I am also responsible for any balances due above payments made by my insurance company.

I appoint Jonathan Heistein, MD, PA to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services, authorizations, or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for providing updated insurance information.

Signature:_____ Date:_____

Jonathan Heistein, MD
Medical Information Questionnaire

Patient Name:_____ **Date of Birth:**____/____/_____

Height:_____ **Weight:**_____

Do you or your family have any of the following medical problems? *(check if applicable)*

	Self	Family	Comments		Self	Family	Comments
HEART DISEASE				**ASTHMA**			
HEART MURMUR				**LUNG DISEASE**			
HIGH BLOOD PRESSURE				**KIDNEY DISEASE**			
CANCER (type?)				**LIVER DISEASE**			
DIABETES MELLITUS				**HEPATITIS**			
STROKE				**THYROID DISEASE**			
BLOOD CLOTS				**DEPRESSION**			
BLEEDING DISORDER				**OTHER**			

Previous Surgeries: *(please list any surgeries that you have had in the past)*

DATE	TYPE OF SURGERY

Previous Hospitalizations: *(please list any time that you were admitted to a hospital)*

DATE	REASON FOR HOSPITALIZATION

Medications: *(include all prescription, over the counter, herbal, and alternative medications and vitamins)*

MEDICATION	DOSE	TIMES PER DAY

Allergies:
(list all allergies including drug allergies)

ALLERGY	REACTION

Social History:

Do you smoke/chew tobacco? □ No □ Yes How much:_____
Do you drink alcohol? □ No □ Yes How much:_____
Do you take recreational drugs? □ No □ Yes What used:_____
Are you employed? □ No □ Yes If yes, what do you do?:_____
Marital status? □ Single □ Married □ Divorced
Do you live alone? □ No □ Yes If no, with whom do you live?:_____

REVIEW OF SYSTEMS- Do you experience or have you ever experienced any of the following? *(If yes, please explain.)*

Fevers? □ No □ Yes_____
Weight change? □ No □ Yes_____
Dry eyes? □ No □ Yes_____
Trouble with your vision? □ No □ Yes_____
Chest pain? □ No □ Yes_____
Rapid heart beat? □ No □ Yes_____
Swollen feet/ankles? □ No □ Yes_____
Shortness of breath? □ No □ Yes_____
Cough? □ No □ Yes_____
Easy bruising/bleeding? □ No □ Yes_____
Swollen lymph nodes? □ No □ Yes_____
Sun burns – severe or mild? □ No □ Yes_____
Skin problems/rashes? □ No □ Yes_____
Problems with urination? □ No □ Yes_____
Joint or muscle pain/arthritis? □ No □ Yes_____
Headaches or migraines? □ No □ Yes_____
Constipation/diarrhea? □ No □ Yes_____
Indigestion or reflux? □ No □ Yes_____
Sinus problems/infections? □ No □ Yes_____
Trouble with your hearing? □ No □ Yes_____
Numbness or paralysis? □ No □ Yes_____
Seizures? □ No □ Yes_____

This Section for WOMEN ONLY:

Age period began _____
Number of pregnancies _____
Date of last period _____
Date of last mammogram _____
Do you do self breast exams? □ No □ Yes_____
Have you ever had a breast lump? □ No □ Yes_____
Did you breast feed? □ No □ Yes_____
Any abnormal mammograms? □ No □ Yes_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.
Patient's Signature: (parent/guardian if minor)_____ **Date:**____/____/_____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Please choose an option:

1.) I consent for these photographs to be used in medical publishing's, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition, to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information, such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

PATIENT SIGNATURE_____WITNESS: _____

2.) I agree for my image to be shown for teaching purposes **AND** to be used for my medical record, but **NOT** for medical publication.

PATIENT SIGNATURE_____WITNESS: _____

3.) I agree to use my image for medical records **ONLY**.

PATIENT SIGNATURE_____WITNESS: _____

If patient is a minor, please complete the area below.
I have read the Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

PARENT/GUARDIAN SIGNATURE_____ DATE _____

NOTICE TO PATIENTS OF FINANCIAL INTEREST

During the course of treatment, you may be referred to Southlake Surgery Center, Baylor Surgical Hospital, or Harris Methodist Southlake (now called Texas Health Resources) for your surgery. You are informed by this Notice that Jonathan Heistein, MD holds a financial interest in these facilities. Investment in these facilities enables us to have a voice in the administration of policies of these facilities. This involvement helps to ensure the highest quality of surgical care for our patients. You have the option, at your discretion, to use an alternative health care facility. You will not be treated differently for using another facility.

Please indicate your receipt of this Notice by your signature below.

_____ _____

Date Patient Signature

_____

Patient Printed Name

Patient Consent for the Disclosure of Information

I have read the Notice of Privacy Practices and have had any questions answered by this office. I understand that by signing this form I consent to the following:

a) **Sharing information for purpose of treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the eduction/wellness programs specified in my insurance plan.
b) **Sharing of information for purposes of payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, ect.) and their representatives involved in the billing process, including, but not limited to, claims representatives, data warehouses, and billing companies.
c) **Sharing of information for purposes of operations:** You will share all information necessary for ongoing operations of this office, including, but not limited to, the credentialing process, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

_____ _____
Patient Signature (or guardian, if a minor) Date

_____
Witness

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communications.

By completing this information, you acknowledge and agree that the office of Jonathan Heistein, MD, it's affiliates, or vendors (including collection or billing companies), may contact you by telephone or text message to any telephonic number you have provided and any telephone number associated with your account, including wireless/mobile devices. I further agree that I may receive auto dialer/prerecorded messages from these parties.

This information shall remain in effect until revoked in writing.

I wish to be contacted in the following manner <u>(check all that apply)</u>

Home Telephone

- ☐ Okay to leave message with detailed information on answering machine
- ☐ Leave message with call-back number only

If you are not home, is there a person we may leave a detailed message with?

Name: _____ Relation: _____

Name: _____ Relation: _____

Work Telephone

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call-back number only

Other Please indicate any other telephone number where you would like to receive phone calls (such as appt reminders, lab results, or other information)

_____

Emergency Contact

Please list any family member or friend that we may inform about your medical condition if we are unable to reach you or in an emergency.

Name:_____ Relation:_____ Phone Number:_____

Name:_____ Relation:_____ Phone Number:_____

Future Correspondence

Would you like to receive future mailings and/or emails regarding upcoming events, new products or procedures, newsletters, ect.? ☐ Yes ☐ No

_____ _____

Patient Signature Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority