Heekin Clinic
ORTHOPEDIC EXCELLENCE

R. David Heekin, MD

o. 904.328.5979 | f. 904.619.9925
2 Shircliff Way, Suite 605 DePaul Building
Jacksonville, FL 32204

HIP PATIENT EVALUATION

☐ RIGHT ☐ LEFT ☐ BOTH (RIGHT/LEFT)

PATIENT NAME: _____ DOB: _____

ONSET: ☐ GRADUAL ☐ SUDDEN ☐ NO INJURY ☐ INJURY

DATE OF ONSET: _____ WORK RELATED? ☐ **YES** ☐ **NO**

How did it happen? Did it swell immediately? _____

_____

_____

Did you go to an emergency department? ☐ **YES** ☐ **NO** NAME: _____

Have you had a similar problem in the past? If so, describe: _____

_____

_____

On a scale from 0-10, mark your average level of pain discomfort during the last week, with 0 being none and 10 being unbearable.

None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Unbearable

Frequency: ☐ Constant ☐ Occasional ☐ Reoccurring

Location: ☐ Anterior (front) ☐ Lateral (outer side) ☐ Posterior (back) ☐ Thigh ☐ Right buttocks ☐ Left buttocks ☐ Groin

Radiation: ☐ YES ☐ NO Where? _____

Quality: ☐ Aching ☐ Burning Dull ☐ Numbness ☐ Piercing ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tearing ☐ Throbbing

Aggravated by: ☐ Climbing stairs ☐ Descending stairs ☐ Jumping ☐ Kneeling ☐ Lifting ☐ Lying down ☐ Climbing stairs ☐ Descending stairs ☐ Jumping ☐ Kneeling ☐ Lifting ☐ Movement ☐ Prolong standing ☐ Sitting ☐ Squatting ☐ Standing ☐ Night pain ☐ Pivoting ☐ Prolong sitting ☐ Running ☐ Standing from a seated position ☐ Twisting ☐ Exercising ☐ Work activities ☐ Daily activities

Relieved by: ☐ Nothing ☐ Elastic wrap ☐ Elevation ☐ Exercise ☐ Ice ☐ Injection ☐ Mobility ☐ OTC meds ☐ Physical therapy ☐ Rest ☐ Stretching ☐ Other _____

Gait Aids: ☐ Not required ☐ Cane ☐ Crutches ☐ Single crutch ☐ Walker ☐ Wheelchair

Associated Symptoms: ☐ Bruising ☐ Clicking ☐ Crepitus(crackling) ☐ Decreased mobility ☐ Difficulty going to sleep ☐ Erythema (redness) ☐ Fever ☐ Grating ☐ Grinding ☐ Joint pain ☐ Limping ☐ Locking ☐ Night-time awakening ☐ Numbness ☐ Popping ☐ Slipping ☐ Snapping ☐ Stiffness ☐ Tenderness ☐ Tingling ☐ Warmth ☐ Weakness ☐ Catching ☐ Pain after inactivity

What has been done so far?

☐ Surgery(type, doctor, and date):

☐ X-rays and Date: _____

☐ MRI and Date: _____

☐ EMG and Date: _____

☐ Other diagnostic testing and Date: _____

☐ Injections: _____ Relief felt: ☐ None ☐ Minimal ☐ Moderate ☐ Significant

☐ Physical Therapy: _____ Relief felt: ☐ None ☐ Minimal ☐ Moderate ☐ Significant

☐ Brace (Describe): _____ Relief felt: ☐ None ☐ Minimal ☐ Moderate ☐ Significant

☐ Medication taken for this problem: _____

PAIN:

During the last month, how frequently did you take medications for pain?

☐ Never ☐ Daily ☐ Several times a week ☐ About once a week ☐ Less than once a week

How would you describe the relief from pain you received with pain medication?

☐ Complete relief ☐ Moderate relief ☐ Very little relief ☐ No relief

Is the pain medication you take prescription or over the counter pain medication?

☐ Prescription ☐ Over the counter ☐ I take both prescription and over the counter medication

Function:

Climbing Stairs: ☐ Able to ☐ Not able to ☐ Finds it difficult to

Putting on socks and shoes: ☐ Able to ☐ Not able to ☐ Finds it difficult to

Clipping toe nails: ☐ Able to ☐ Not able to ☐ Finds it difficult to

Walking: ☐ Unlimited ☐ 10 blocks ☐ 5 — 10 blocks ☐ Limited to walking inside house

Getting in the car: ☐ Must get help ☐ Does not need help

What activities does your pain prevent you from doing? _____

_____

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REVIEW OF SYSTEMS

NAME: _____ DOB: _____ DATE: _____

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular
- ☐ Chest pain
- ☐ Cyanosis
- ☐ Heart Murmur
- ☐ Irregular heartbeat/ palpitations
- ☐ Leg swelling
- ☐ Syncope (fainting)

Skin/Integumentary
- ☐ Contact allergy
- ☐ Itchy skin
- ☐ Rash
- ☐ Skin Infection
- ☐ Skin lesion

Metabolic/endocrine
- ☐ Cold intolerant
- ☐ Hair loss
- ☐ Heat intolerant

HEENT
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dysphagia (problem swallowing)
- ☐ Ear drainage
- ☐ Facial pain
- ☐ Headache
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nasal congestion
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Vision loss

Gastrointestinal
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Black tarry stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

Neurological
- ☐ Difficulty walking
- ☐ Dizziness
- ☐ Poor coordination
- ☐ Memory loss
- ☐ Muscle weakness
- ☐ Paresthesia (numbness or tingling)
- ☐ Seizures
- ☐ Tremors

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomia

Respiratory
- ☐ Chest pain (respiratory)
- ☐ Cough
- ☐ Dyspnea (Shortness of Breath)
- ☐ Recent infections
- ☐ Known TB exposure
- ☐ Wheezing

Genitourinary
- ☐ Dysuria
- ☐ Frequent urination
- ☐ Hematuria
- ☐ Urge incontinence
- ☐ Urinary incontinence

Hematologic
- ☐ Bleeding
- ☐ Bruising

Immunological
- ☐ Asthma
- ☐ Bee sting allergies
- ☐ Contact dermatitis
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

HEIGHT: _____ **WEIGHT:** _____

(office use only) BP: _____

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NAME: _____ DOB: _____ DATE: _____

MEDICATIONS AND ALLERGIES

Please attach medication list if availabe.

Medication or Vitamin Name:	Dosage	Reason for taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

DRUG ALLERGIES	REACTION
1.	
2.	
3.	
4.	
5.	

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NAME: _____ DOB: _____ DATE: _____

PAST MEDICAL HISTORY

Please select if condition applies to your medical history:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina (Chest Pain)
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Enlarged Prostate (hypertrophy)
- ☐ Cancer:
- ☐ CVA (Stroke)
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (blood clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD (Acid reflux)
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol (hyperlipidemia)
- ☐ Hypertension (High Blood Pressure)
- ☐ Inflammatory bowel disease
- ☐ Juvenile Rheumatoid Arthritits
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyne Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peptic Ulcers
- ☐ Psoriasis
- ☐ PVD (Vascular Disease)
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apenea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Spondyloarthropathy
- ☐ Thyroid Disease
- ☐ Valvular Disease

Other: _____

PAST SURGICAL HISTORY: Pleas list all previous surgeries that required anesthesia.

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY	Father	Mother	Siblings	Grandparents	Other _____
Arthritis	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High BP	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

SOCIAL HISTORY:

Tobacco Use: ☐ Yes ☐ No ☐ Former Type: _____ Packs per day: _____ Years smoked: _____ Year Quit: _____

Alcohol Use: ☐ Yes ☐ No ☐ Former Type: _____ Frequency: _____ Amount per day: _____ Last Drink: _____

Caffeine Use: ☐ Yes ☐ No Type: _____ Amount per day: _____

Activity: ☐ Moderate ☐ Sedentary ☐ Vigorous Type(s) of exercise: _____ Frequency: _____

Occupation: Employer: _____ Job Title: _____ Work Station: ☐ P/T ☐ F/T ☐ Disabled ☐ Retired

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

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Workman's compensation

We will require workman's compensation information including: adjuster's name, e-mail, phone number and fax number, date of injury, valid claim number and carrier information. If this information is not received your scheduled appointment will be rescheduled.

Auto Policy

Heekin Clinic will file your auto insurance, if your benefits exhaust prior to your completion of treatment your Health insurance will be filed. At that time you are responsible for any copays, deductibles and co-insurance amounts associated with your health insurance, Heekin Clinic does not accept Letter of Protection from any attorney for these amounts.

Monthly Statements

You will receive monthly statements, if you have a balance on your account after your insurance pays its portion. All patient due balances are to be paid within thirty (30) days. If you are unable to pay in full, we expect you to contact our business office to make payment arrangements. There will be a flat $10 fee for sending additional statements each month any default on the arrangements or failure to commit to your financial responsibilities will involve a third party collection agency. You will incur a 30% collection fee, in addition you will be discharged from the practice until this obligation is met.

Returned Checks

Any returned check will be subject to a $35.00 service fee. This will need to be resolved before any future treatment is scheduled.

Paperwork

This is a $25.00 charge for any additional paper work unassociated with your health insurance. Examples: Disability forms, FMLA forms, work status notes, etc. I have been given a copy of this agreement and agree to abide by this financial policy.

Minor Children

All children under the age of 18 years old must be accompanied by a parent or guardian.

Patient Name: _____

Patient Signature: _____

Parent Name if Patient is a Minor: _____

Date: _____

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PATIENT FINANCIAL POLICY

We are committed to providing excellent care to our patients-regardless of insurance coverage or financial limitations. Your understanding of our financial policy is extremely important to our business and we will work with you to simplify the process. Please read carefully and if you have any questions please ask for clarifications.

Insured Patients:

Our business relationship is with our patients and families, not insurance companies. However the insurance carriers have considerable influence on this relationship. In order for our office to file a claim with your insurance company we must have valid insurance cards on file. If one is not given to our office, you will be responsible for payment in full for any services rendered on that day, or your appointment may be rescheduled, based on your particular insurance policy. Once your insurance information is complete, we will file your claims with your insurance company. **All Charges incurred are your responsibility if your insurance company chooses not to pay for any reason.**
It's important for you to read your policy handbook provided and to understand and know which services are covered and which may be considered "not medically necessary" The physician may perform services that fall within this category and this does not relieve you of the financial obligation.

Requirements from you insurance company:

Any co-pay required by an insurance company must be paid in full at the time of service. Because this is an insurance requirement, we cannot bill you for this co-pay. If you are unable to pay your co-pay you may be required to reschedule your appointment.
If you participate in a HMO or a manage contract that requires an authorization (referral), you are responsible for obtaining and bringing this in on your scheduled appointment. It is your responsibility to keep track of the number visits used and update as necessary. If you do not have an updated or effective authorization on file your appointment will be rescheduled.

Uninsured Patients:

If you are uninsured payment for office related services are due at the time services are rendered, unless. There may be a need to arrange a payment plan for any elective surgical procedure at the time the procedure is scheduled. Customarily, our policy requires 50% of the surgeons fee paid prior to scheduling.

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Name: _____ DOB: _____

Authorization and Assignment of Benefits

For the services rendered and those about to be rendered, I hereby assign to Heekin Clinic, all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Heekin Clinic and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Heekin Clinic. I understand that I am directly and primarily responsible to Heekin Clinic for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Heekin Clinic to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

Signature: _____ Date: _____

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be payable to Heekin Clinic for my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

Signature: _____ Date: _____

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STATEMENT OF POLICIES

The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

1. Heekin Clinic strictly provides orthopedic services only. Patients are expected to have or arrange for a Primary Care Physician.
2. Deductibles and Co-Pays are payable at the time of service. **Any previous balance is expected to be paid at time of service.**
3. Patients are responsible for obtaining referrals and authorizations for services rendered at Heekin Clinic.
4. If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel the appointment. Failure to do so may incur a $30.00 charge to your account for the missed appointment.
5. There is a $25.00 fee for all disability, FMLA, and other forms/ paperwork that you need to have filled out by the physician. We may ask that you make an appointment to complete these forms.
6. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc...This charge will be determined by the information requested.
7. Prescription Policies:
   - If you are in need of a refill, please have your pharmacy fax a request to 904.619.9925. Please allow 48 to 72 hours.
   - Refills will be called in only between 9am-5pm Monday through Friday. No refills after 5pm on weekdays. No refills on weekends.
   - You will not be prescribed pain medication unless and until such time that you need surgery. Once surgery is performed, you may receive pain medication only up to 90 days after surgery.
   - If you continue to need pain medication past 90 days after surgery, or for the treatment of pre operative pain or chronic pain, you will require an office visit to discuss this with your provider.

I acknowledge that I have carefully read and understand the Statement of Policies, and agree to abide by them.

Name (please print) _____ DOB _____

Signature: _____ Date: _____

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PATIENT DEMOGRAPHIC

DATE: _____ MARITIAL STATUS: ☐ M ☐ W ☐ S ☐ D

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ AGE: _____

CITY: _____ STATE: _____ ZIP: _____ SSN: _____

HOME PHONE: _____ ALT PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

MAY WE CONTACT YOU VIA EMAIL? ☐ **YES** ☐ **NO** EMAIL ADDRESS: _____

ARE YOU A VETERAN? ☐ **YES** ☐ **NO** DRIVER'S LICENSE #: _____

SPOUSE NAME: _____ DOB: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE NAME: _____ ID#: _____

PRIMARY CARD HOLDER NAME: _____ DOB: _____ RELATION: _____

SECONDARY INSURANCE NAME: _____ ID#: _____

SECONDARY CARD HOLDER NAME: _____ DOB: _____ RELATION: _____

IS THIS ACCIDENT OR INJURY RELATED TO: AUTO JOB OTHER DATE OF INJURY: _____

PRIMARY CARE PHYSICAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

PHYSICAL THERAPY FACILITY: _____ PROVIDER: _____

PAIN MANAGEMENT FACILITY: _____ PROVIDER: _____

TO BE IN COMPLIANCE WITH FEDERAL GUIDELINES, PLEASE INDICATE WHICH OF THE FOLLOWING BEST DESCRIBES YOU:

RACE:
- ☐ American Indian or Alaska Native
- ☐ More than one race
- ☐ Other
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown/Not Reported
- ☐ Black or African American
- ☐ White

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

PRIMARY LANGUAGE: _____

HOW DID YOU HEAR ABOUT The Heekin Clinic?

☐ Referred By: _____ ☐ Friend ☐ Family ☐ Physician ☐ PT ☐ PA

- ☐ 1 010XL/Sports Radio
- ☐ Attorney
- ☐ Billboard
- ☐ Bumps and Bruises
- ☐ Health Fair
- ☐ High School
- ☐ Heekin Clinic Website
- ☐ Print Ad
- ☐ Radio
- ☐ River Run
- ☐ Search Engine
- ☐ Social Media
- ☐ TV
- ☐ Vitals/Health Grades
- ☐ Yellow Pages

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PRIVACY NOTICE

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

At The Heekin Clinic, we are committed to treating and using your protected health information. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Yours Health Record/Information

Each time you visit The Heekin Clinic, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

*Basis for planning your care and treatment,
*Means of communication among health professionals who contribute to your care,
*Legal document describing the care you received,
*Means by which you or a third-party payer can verify that services billed were actually provided,
*A source of data for medical research
*A source of information for public health officials charged with improving the health of this state and the nation,
*A source of data for our planning and marketing,
*A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing discloser to others.

Your Health Information Rights

Although your health record is the physical property of The Heekin Clinic, the information belongs to you. You have the right to:
*Obtain a paper copy of this notice of information practices upon request,
*Inspect and copy your health record as provided for in 45 CFR 164.524,
*Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528, *Request communications of your health information by alternative means or at alternative locations, *Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and *Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

The Heekin Clinic is required to:
*Maintain the privacy of your health information, *Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
*Abide by the terms of this notice,
*Notify you if we are unable to agree to a requested restriction, and
*Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. **We will not use or disclose your health information about your authorization, except as described in this notice.** We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

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For More Information or to Report a Problem.
If you have questions and would like additional information, you may contact the practice's Privacy Officer, Katherine Johnson at (904) 328.5979.
If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S Department of Health and Human Services 200 Independence Avenue, S.W
Room 509 F, HHH Building
Washington, D.0 20201
Examples of Disclosures for Treatment, Payment and Health Operations
2627 Riverside Ae Ste 300 Jacksonville, FL 32204
10475 Centurion Parkway, Ste.220 Jax, FL 32256
Phone (904) 634-0640 Fax (904) 634-0203
www.heekinclinic.com

We will use your health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

Business associates: There are some services provided in our organization through contacts and business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your insurance company or third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from offices:
We may call your home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. We may mail to your home or other designated location any items that assist the

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practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. We may email to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer. Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
Workers compensation: We may disclose health information to the extent authorization by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Patient Name: _____

DOB: _____

Patient Signature: _____

Name(s) of others authorized to discuss or request medical information: _____

_____

_____

_____

_____

Heekin Clinic
ORTHOPEDIC EXCELLENCE

R. David Heekin, MD

o. 904.328.5979 | f. 904.619.9925
2 Shircliff Way, Suite 605 DePaul Building
Jacksonville, FL 32204

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NAME (Please Print): _____ (DOB ___ / ___ / _____)

I hereby acknowledge that I have been provided the **Notice of Privacy Policy** for Heekin Clinic. The notice explains in more detail how Heekin Clinic may use and/or share my health information in regards to treatment, payment, and health care operations. I was given the opportunity to ask questions regarding this policy.

I will allow Heekin Clinic to discuss my medical, payment, scheduling, and health care operations with the following individuals:

1. Name: _____
   Relationship: _____
   Phone Number: _____

2. Name: _____
   Relationship: _____
   Phone Number: _____

Signature: _____ Date: _____

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Jacksonville, FL 32204

Cancellation List

If you would like to have your surgery sooner and would like to be placed on our cancelation list, we must have your completed medical clearances before we can add you to the list. Once on the list, you may only have a day or two to prepare for the surgery. Because of this, we strongly recommend that you ask your primary care physician ahead of time to order the following tests:

- CBC
- Chem- 7 (Basic Metabolic Panel)
- EKG
- CXR

Obtain copies of all tests results and keep them with you.

When we have a cancelation we will call you to see if you are available. If you are not available you will stay on the list for the next date that comes available.

Please note that our surgery schedule can change due to cancelations and emergent cases. All scheduled procedures are considered "elective" and emergency procedures take priority. Canceling elective cases rarely happens but if it does, we will immediately re-schedule your surgery and do our best to accommodate you to minimize the disruption of your plans for you and your family/friends.

Please contact Shar Johnson at (904) 328.5979 if you have any questions, concerns or if you need to reschedule your procedure.