RORY C. DUNHAM, D.O.

Oklahoma Sports Science and Orthopaedics

9060 HARMONY DRIVE, MIDWEST CITY, OK 73130 – P: 405.759.2562 - F: 405.703.4870

OSSO
AN HPI AFFILIATE

PATIENT INFORMATION

Date	Referring Physician		Referring Physician Phone	
Last	First		Middle	Sex: ____M ____F
Address	City		State	Zip
Home Phone	Age	DOB:	Marital Status: S M W D DEP	SS#
Employer/School	Address	City	State	Zip
Work Phone	Cell Phone	Pager	E-Mail	
Nearest Relative (other than spouse)		Relation	Contact Number	

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient		Home Phone	
Address	City		State	Zip
Employer	SS#	DOB	Age	Work Phone:

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance		Insurance Type Group _____ Individual _____ COBRA _____	
Address	City	State	Zip
Insured's Name on Card		ID#	Group#
Insured's DOB	Relation to Insured	Insured Sex M ___ F ___	Insured SS#
Insured's Employer		Insured's Phone	

Secondary Insurance		Insurance Type Group _____ Individual _____ COBRA _____	
Address	City	State	Zip
Insured's Name on Card		ID#	Group#
Insured's DOB	Relation to Insured	Insured Sex M ___ F___	Insured SS#
Insured's Employer		Insured's Phone	

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Oklahoma Sports Science and Orthopaedics. I am financially responsible for any charge not covered by my insurance.

_____ _____

Patient or Authorized Person Date

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NEW PATIENT QUESTIONNAIRE

Date			
Name		Phone	
Age	Sex	Height	Weight
Race/Ethnicity		Language	
Family Physician		Referred By	
Reason For Visit		Is this injury work related?	
___ Right ___ Left ___Bilateral		Occupation	
Date of Onset/Injury (Insurance Requires Approx. Date) Month:_____ Day:_____ Year:_____			
Hand Dominance: R or L	Current Level of Function: 0-100 (0 being worst)		Current Level of Pain: 0-10 (10 worst)
Have you seen a doctor in the past for this problem? Yes/No, Who, When, Where?			
Explain your condition or how your injury occurred:			
What treatment have you had? (Please circle) Rest Medication Therapy Injections Other:_____			
Have you had any previous diagnostic tests? (Please circle) MRI X-Ray CT Scan Other:_____			

CIRCLE ANY MEDICAL PROBLEMS LISTED THAT YOU HAVE OR HAVE HAD IN THE PAST: (CIRCLE ALL THAT APPLY)

NO KNOWN MEDICAL PROBLEMS	HIGH BLOOD PRESSURE	HEART DISEASE/HEART ATTACK
LIVER DISEASE/HEPATITIS	DIABETES	COPD/EMPHYSEMA
ULCERS	CANCER	TUBERCULOSIS
THYROID DISEASE	IMMUNE DISORDER	BONE INFECTION
PERIPHERAL VASCULAR DISEASE	ASTHMA	SEIZURE DISORDER
STROKE	SLEEP APNEA	OVERWEIGHT/OBESITY
OTHER:		

Tobacco Usage: Y/N Packs per day: _____ How many years:_____ Alcohol Usage: NONE/OCCASSIONAL/DAILY/> 4 DRINKS/DAY

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING: (CIRCLE ALL THAT APPLY)

NONE KNOWN	CANCER	LEUKEMIA	CORONARY ARTERY DISEASE
RHEUMATIC FEVER	DIABETES	HYPOTHYROIDISM	HIGH BLOOD PRESSURE
TUBERCULOSIS	COLITIS	STROKE	BLEEDING TENDENCY
ASTHMA	SEIZURES	OTHER:	

WHAT SURGERIES HAVE YOU HAD IN THE PAST: (CIRCLE ALL THAT APPLY)

NO PREVIOUS SURGERY	HYSTERECTOMY	MASTECTOMY	APPENDECTOMY
HERNIA REPAIR	CABG/OPEN HEART	GALLBLADDER	CATARACT EXTRACTION
PROSTATE SURGERY	LUMBAR SPINE SURGERY	TONSILLECTOMY	OTHER:

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MEDICATION/ALLERGY SHEET

NAME: _____ D.O.B. _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (BOTH PRESCRIPTION AND NON-PRESCRIPTION)

MEDICATION	DOSE	# TIMES A DAY

CIRCLE ANYTHING LISTED BELOW TO WHICH YOU ARE ALLERGIC:

NO KNOWN DRUG ALLERGIES	CODEINE
PENICILLIN	IODINE/BETADINE
TETRACYCLINE	RADIOGRAPHIC DYES
SULFA	ADHESIVE TAPE
MORPHINE	ERYTHROMYCIN
OTHER:	

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REVIEW OF SYSTEMS

NAME: _____ D.O.B. _____

PLEASE CIRCLE ALLTHAT CURRENTLY APPLY

GENERAL CONSTITUTIONAL	EYES AND VISION	EARS, NOSE, THROAT
GOOD GENERAL HEALTH	WEAR GLASSES/CONTACTS	SWOLLEN GLANDS IN NECK
RECENT WEIGHT CHANGE	BLURRED/DOUBLE VISION	EARACHES OR DRAINAGE
FATIGUE	EYE DISEASE OR INJURY	SINUS PROBLEMS
FEVER	GLAUCOMA/CATARACT	RINGING IN EARS
		HEARING LOSS
		NOSE BLEEDS
RESPIRATORY	**CARDIOVASCULAR**	**GASTROINTESTINAL**
SHORTNESS OF BREATH	SWELLING OF EXTREMITIES	CHANGE IN BOWEL MOVEMENTS
ASTHMA OR WHEEZING	IRREGULAR HEARTBEAT	NAUSEA/VOMITING/DIARRHEA
FREQUENT COUGHING	HEART TROUBLE	LOSS OF APPETITE
SPITTING UP BLOOD	CHEST PAINS	CONSTIPATION
		BLOOD IN STOOL
		ULCERS
GENITOURINARY	**MUSCOLOSKELETAL**	**NEUROLOGICAL**
BURNING/PAINFUL URINATION	JOINT PAIN/STIFNESS/SWELLING	LOSS OF CONSCIOUSNESS
STRAIN WITH URINATION	WEAKNESS OF MUSCLE JOINTS	LIGHT HEADED OR DIZZY
FREQUENT URINATION	CHANGE IN HAT OR GLOVE SIZE	NUMBNESS OR TINGLING
BLOOD IN URINE	MUSCLE PAIN OR CRAMPS	SEIZURE OR STROKE
KIDNEY STONES	DIFFICULTY WALKING	SEVERE HEADACHES
INCONTINENCE	COLD EXTREMITIES	HEAD INJURY
FREQUENT UTI	BACK PAIN	PARALYSIS
		TREMORS
PSYCHIATRIC	**ENDOCRINE**	**LYMPHATIC/HEMATOLOGICAL**
MEMORY LOSS/CONFUSION	EXCESSIVE THIRST/URINATION	EASILY BRUISE OR BLEED
SLEEP PROBLEMS	GLAND/HORMONE PROBLEM	SLOW TO HEAL AFTER CUT
NERVOUSNESS	HEAT/COLD INTOLERANCE	TRANSFUSION REACTIONS
DEPRESSION	CHANGE IN SKIN COLOR	PHLEBITIS/BLOOD CLOTS
	THYROID DISEASE	SWOLLEN GLANDS
	RASH OR ITCHING	ANEMIA
	DIABETES	
	DRY SKIN	

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PHARMACY INFORMATION

Please provide us with your preferred pharmacy information. We will only refill prescriptions to the pharmacy we have on file for you.

Tricare Patients: Please note that we are able to call-in, fax or e-prescribe prescriptions to military post/base pharmacies. Please provide us with a civilian pharmacy that accepts your insurance.

PHARMACY: _____

ADDRESS: _____

PHONE: _____

All questions **MUST** be filled in. Please do not leave anything blank.

I _____understand that I can only use one pharmacy for prescriptions to be called in from this office.

Patient's Signature: _____

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DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Rory C. Dunham has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visits our website(s), communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____ _____
Signature of Patient Signature of Parent/Guardian (if applicable)

_____ _____
Print Name of Patient Print Name of Parent or Guardian

_____
Date

HPI COMMUNITY HOSPITAL

HPI NORTHWEST SURGICAL HOSPITAL

HPI COMMUNITY HOSPITAL IMAGING CENTER

HPI COMMUNITY HOSPITAL OUTPATIENT THERAPY

HPI NORTHWEST SURGICAL HOSPITAL LAKEPOINTE IMAGING CENTER

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____, acknowledge that I have received a copy of The Physicians' Group or HPI Physicians, LLC ("the Practice")Notice of Privacy Practices ("the Notice"). This Notice describes how the practice may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient

ACCESS TO MEDICAL RECORDS

The person or persons listed below may have access to my medical records.

Name	Relation to patient
Name	Relation to patient
Name	Relation to patient
Name	Relation to patient

CONSENT TO DISCUSS DIAGNOSIS AND TREATMENT WITH ATHLETIC TRAINER

☐ I authorize The Physicians' Group or HPI Physicians to discuss my diagnosis and treatment with my school's athletic training staff. I have read each of the above paragraphs and fully agree to each of the statements. I acknowledge my agreement by signing below.

_____ _____
Patient Date

_____ _____
Parent or Guardian Date

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WORKERS' COMPENSATION

Patient	DOB	SSN		
Patient Address	City	State	Zip	
Home Phone	Mobile Phone			
Employer Address	City	State	Zip	
Are you claiming this as an on the job injury?	Yes_____ No _____		Date of Injury:	
What type of injury?	How did it occur?			
Work Comp. Company				
Work Comp. Address	City	State	Zip	
Contact Person	Phone		Fax	
Nurse Case Manager	Phone		Fax	
Claim Number	Verified By			
If yes, are you receiving compensation (circle one)	Yes		No	
Do you have an attorney?	Yes	No	If yes, who?	
Were you referred to our office?	Yes	No	If yes, who?	
Have you been treated by any other doctor for this injury? Yes_____ No_____				
If yes, who	Phone Number			

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how The Physicians' Group, LLC or HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment and healthcare operations.
- The Notice explains in more detail how the Practice may use and share protected health information other than treatment, payment and healthcare operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient Name (print): _____

Patient Date of Birth: _____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

_____

_____

_____ Date:_____
Signature of Patient or Patient's Personal Representative

Current contact information for patient or personal representative signing this form:

Name (print): _____

Address: _____

Telephone: _____

E-mail: _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgement but did not because:

_____ It was emergency treatment
_____ I could not communicate with the patient
_____ The patient refused to sign
_____ The patient was unable to sign because _____
_____ Other: _____

_____ _____ _____
Signature Practice Staff Member | Name (please print) and title | Date

This form should be placed in patient's medical record.

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11-1-15

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Print Patient Name: _____ DOB: _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management and/or anxiety management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly, as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines and stimulants may cause addiction, and is only one part of a complete treatment plan.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine not prescribed to me.
2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
4. I will not increase my medicine until I speak with my doctor or nurse.
5. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
6. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
7. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
8. I agree to come to the office for a pill count at any time if asked by my doctor.
9. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
10. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test, and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit, and again randomly through the course of my treatment.
11. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
12. I have been informed by my physician about narcotic effects, including the normal physiological effects of tolerance (where I might need to take more medication to obtain the same pain relief), and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
13. I understand that narcotics can adversely affect my judgment in making business decisions, and in operating equipment such as an automobile.
14. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
15. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence that I am improving, or that progress is being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician.
16. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

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11-1-15

Refills

- I understand that refills of narcotic medication will be given only during my regularly scheduled appointment, or once monthly by telephone if the current prescription has been correctly used. If the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.
- I understand that refills will be made only during regular office hours—Monday through Thursday, 8:00 AM-4:30 PM and Friday 8:00 AM-12:00 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 3 business days is required.
- I must keep track of my medications. No early or emergency refills may be made.
- Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before a new prescription will be written.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is _____.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if narcotics have been obtained from another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way, and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

I have talked about this agreement with my doctor and I understand the above rules.

Patient's signature _____ Date _____

Physician's signature _____

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OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

A DIVISION OF THE PHYSICIANS' GROUP

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopaedics (OSSO) are you healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care. We specialize in adult and pediatric orthopaedics, sports medicine, physical medicine and rehabilitation, pain management, reconstructive and orthopedic spine surgery and hand surgery.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card, or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.692.3708 to make financial arrangements. Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

If your injury was due to a motor vehicle accident (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. **Please note that not all OSSO Physicians will accept third party/MVA patients.**

There is a $35 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Oklahoma Sports Science & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed_____ Date_____
(Signature of person financially responsible for payment)

Relationship if other than patient_____