Jimmy H. Conway Jr., M.D. Robert S. Unsell, M.D. 10001 S. Western, Ste 101 OKC, OK 73139 405-692-3700

PATIENT INFORMATION
(please fill in all blanks)

Patients Legal Name: Last	First	M.I.	Sex:	DOB:	Age:

Social Security Number:	Email Address: Declined ☐	Marital Status: ☐Married ☐ Widowed ☐Divorced ☐ Separated ☐Single	Spouses Name:

Patients Address:	Employment Status: ☐ Employed ☐ Full-time student ☐ Part-time student ☐ Retired

City:	State:	Zip:	Referring Physician:

Home Phone:	Work Phone:	Cell Phone:	Preferred Language:

Ethnicity: ☐Hispanic ☐ Non-Hispanic ☐Declined	Race: ☐ White ☐ Asian ☐ Black ☐ Pacific ☐Native American ☐Multiple ☐ Other

INSURANCE INFORMATION – We will need a copy of the insurance card in order to file a claim.

Name of the Primary Insurance Company ______________________________

Name of the person who carries the insurance policy ______________________________ Relationship to Patient ______________

Carriers DOB ______________________ Carriers SS# ______________________

Carriers Employer ______________________________

Seconday Insurance ______________________________

Carriers DOB ______________________ Carriers SS# ______________________

Carriers Employer ______________________________

EMPLOYMENT INFORMATION

N / A ☐ Patients Employer ______________________________ Phone Number ______________

N / A ☐ Insured Employer ______________________________ Phone Number ______________

If Patient is a minor, please list both parents names and employers

N / A ☐ Mother ______________ Employer ______________ Phone # ______________

Father ______________ Employer ______________ Phone# ______________

NEXT-OF-KIN INFORMATION

Nearest Relative (or Friend, Not Souse) Not living with you:

Home Phone: Relationship to patient:

WHO REFERRED YOU TO OUR OFFICE?

Adjuster	Attorney	Billboard	Case Manager	Doctor	Employer	Friend	Hospital	Insurance Company	Magazine
Neighbor	Phone Book	Coach	Physical Therapist	School	Trainer	Radio	Other		

THIRD PARTY BILLING

Is your injury work related?	YES	NO
Is this injury due to an accident?	YES	NO
If your injury is MVA related, have you obtained an accident report?	YES	NO

I hearby authorize my insurance benefits to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non covered services. I also authorize the physician to release my informationin the processing of any insurance claims. I acknowledge that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

Jimmy H. Conway, M.D.
New Patient Information Form

Name: ______________________ SS#: ______________________

Age: __________ Height: ______________ Weight: ______________________

Primary Care Physician Name and Phone Number: ______________________

Referring Physician and Phone Number: ______________________

Reason for Today's Visit: ______________________

Is this injury related to work? ______________ Auto Accident? ______________

<u>FILL OUT **ALL** BELOW AS YES OR NO</u>

Past Medical History	YES	NO	Please **DETAIL ALL YES ANSWERS** below:
Eye, Ear, Nose, Throat problem	___	___	
Heart Disease	___	___	
High Blood Pressure	___	___	
Lung Disease	___	___	
Kidney/Liver Disease	___	___	
Stomach/Intestinal Disease	___	___	
Bone/Joint/Muscle Disease	___	___	
Diabetes	___	___	
Epilepsy	___	___	
Arthritis	___	___	
Cancer	___	___	
Vascular Disease	___	___	
Psychiatric Problems	___	___	
Anesthesia Problems	___	___	
HIV/AIDS	___	___	
Thyroid Problems	___	___	
Abnormal Bleeding	___	___	
Jaundice	___	___	
Hepatitis	___	___	
Mono	___	___	
Stroke	___	___	
CABG	___	___	
Abnormal Infections	___	___	
MRSA	___	___	
MRSE	___	___	
Anticoagulant Therapy (Blood Thinners)	___	___	
Alcohol Use	___	___	Amount/Duration:
Drug Use	___	___	Amount/Duration:
Tobacco Use	___	___	Amount/Duration:

<u>IF NONE APPLIES, PLEASE INDICATE "NONE" BELOW</u>

Family History of Above: ______________________

Past Surgical History: ______________________

Medications: ______________________

Allergies (please list all drugs/foods/dyes): ______________________

Prior Hospitalizations: ____

____

Current Employment: ____

Occupational History: ____

Highest Level of Education: ____

Recreational Activities: ____

FILL OUT **ALL** BELOW AS YES OR NO

SYSTEM REVIEW	YES	NO	If yes, please explain.
Headache, dizziness, visual disturbances	___	___	___
Throat trouble, ringing in ears, runny nose	___	___	___
Chest pain, palpitations, irregular heart beat	___	___	___
Shortness of breath, cough	___	___	___
Heartburn, nausea, vomiting, diarrhea	___	___	___
Burning, frequency of urination or vaginal discharge	___	___	___
Muscle, bone, joint pain or stiffness	___	___	___
Changes in skin color, texture, moles or rashes	___	___	___
Swellings, discolorations, temp. change of extremity	___	___	___
Loss of sensation	___	___	___
Lower back pain	___	___	___
Fever, chills, sweats, fatigue	___	___	___
Easy bruising or bleeding disorder	___	___	___
Weight loss or gain	___	___	___
Excessive thirst or hunger	___	___	___
Excessive worry, anxiety, depression	___	___	___
Dietary restrictions	___	___	___
Glasses or contacts	___	___	___
Dentures or partials	___	___	___

WORKER'S COMPENSATION INFORMATION

(Complete if applicable)

1. Date of work injury ____
2. Injured part the claim covers ____
3. Work title with description ____
4. Currently working (circle) YES NO
5. Current work restrictions ____
6. Last day worked ____

Signature ______________________________ Date ______________________________

Chart No. ______________

Oklahoma Sports Science and Orthopaedics

Authorization to Release Information via phone/Family/Friends

Patient Name: ______________________________ DOB: ______________

I hereby authorize confidential communications from the physicians or staff of OSSO regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: ______________ Work Phone: ______________ Cell phone: ______________

Other: ______________

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: ______________ Relation: ______________

Name: ______________ Relation: ______________

Name: ______________ Relation: ______________

Name: ______________ Relation: ______________

I understand this authorization will remain in effect until I revoke the authorization in writing.

______________________________ ______________

Patient Signature Date

OSSO STAFF ONLY:

Documented by:

________ ________

Initials Date

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopaedics to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Sports Science & Orthopaedics to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Oklahoma Sports Science & Orthopaedics charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Sports Science & Orthopaedics, it agents and it employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Sports Science & Orthopaedics. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing for fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Sports Science & Orthopaedics from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED ______________________________ DATE ______________________
(PATIENT)

OR______________________________
(NEAREST RELATIVE OR RESPONSIBLE PARTY)

______________________________ POLICYHOLDER'S SIGNATURE ______________________
(RELATIONSHIP TO PATIENT)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made a confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.

<u>Oklahoma Sports Science & Orthopaedics</u>

A division of The Physicians' Group

Financial Policy

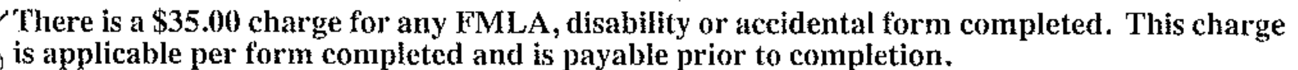
Thank you for choosing "Oklahoma Sports Science & Orthopaedics" as your healthcare provider. At OSSO we are dedicated to providing the highest quality, most cost effective care specializing in Adult & Pediatric Orthopedics, Sports Medicine, Running Injuries, Physical Medicine and Rehabilitation, Pain Management, Reconstructive & Orthopedic Spine Surgery and Hand Surgery.

In additional 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 to each appointment your current insurance card, or any other information that is required by your insurance carrier. 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 Card, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 692-3700 to make payment 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 you will be set up on a self-pay account for any charges incurred up to $500.00. If charges exceed $500.00, 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 $35.00 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 at Saints North 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 & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: ____ Date______________

(Signature of person financially responsible for payment)

Relationship if other than patient: ____

Oklahoma Sports Science & Orthopaedics

- The pain you are experiencing may be improved, but not eliminated, with the use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be phoned in should you be unable to keep these appointments.
- This office fills pain medications for surgical patients only. They are not filled indefinitely. After a period of time your doctor will taper your medications for discontinuation. If discontinuation is not possible or you are not a surgical candidate you will be referred for long-term pain management.
- Your treating physician is to be the only physician who prescribes narcotic pain medications to you.
- It is your responsibility to notify us of any other physician who is prescribing narcotic pain medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing you narcotic pain medications.
- Individuals must be aware that " doctor shopping " is viewed as narcotic drug seeking behavior and is not tolerated. Should this type of behavior occur, your narcotic pain medications will not be refilled and you will be dismissed as a patient.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- Pain medication refill requests are taken and called in MONDAY thru FRIDAY from 8:30 am to 3:30 pm ONLY. PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS, OR AFTER HOURS FOR ANY REASON. We guarantee prescription refills will be processed within 48 hours of the request.
- Federal and state law carefully regulates dispensed or written prescriptions for narcotic medications. Forging or altering a narcotic prescription, or distributing medications to others of their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and be reported to the DEA, Police and FDA.
- Lost, stolen, or misplaced prescriptions or medications ARE NEVER REPLACED- NO EXEPTIONS. Your medications and prescriptions are your responsibility.
- Narcotic pain medications may cause sedation and dizziness. You should not drive an automobile nor operate any machinery when taking medications.

Informed consent: I,____, have been informed and clearly understand the above listed issues regarding the treatment of pain with narcotic pain medications. I understand that this agreement will be filed in my chart as a part of my permanent medical record.

Signature__________________________________ **Date**__________________

DISCLOSURE OF PHYSICIAN ACKNOWLEDGEMENT
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

This notice is to inform you that Dr. Jimmy Conway is a paid consultant for Lima Corporate, an Italian based Orthopedic company. Dr Conway uses the Lima SMR implants for his total shoulder arthroplasties and his reverse total shoulder arthroplastics.

By signing this Disclosure of Physician Acknowledgement, you acknowledge that you understand the foregoing notice and hereby understand that your physician is a paid consultant for Lima Corporate.

______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Print Name of Patient	Print Name of Parent or Guardian

Dated: ________________________

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. Jimmy H. Conway, M.D. 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 health care 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 visit our website at 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 or 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

NEW PATIENT / NEW CONDITION

SHOULDER

NAME: ________________________________

AGE:__________

HAND DOMINATE: RIGHT / LEFT

WHERE DOES YOUR SHOULDER HURT? RIGHT OR LEFT

FRONT OF SHOULDER:	YES	NO
BACK OF SHOULDER:	YES	NO
SIDE OF SHOULDER:	YES	NO
SHOULDER BLADE:	YES	NO
NECK:	YES	NO

IS THERE PAIN IN THE ARM, FOREARM, OR HAND? YES NO

IF YES, WHERE DOES IT HURT? ________________________________

IS THERE NUMBNESS OR TINGLING? YES NO

IF YES, WHAT AREA DOES IT OCCUR? ________________________________

WHEN DID THE PROBLEM START? ________________________________

IS IT DUE TO AN INJURY? YES NO

IF YES, WHAT HAPPENED? ________________________________

____

HAVE YOU BEEN TREATED BY ANOTHER HEALTHCARE PROVIDER? YES NO

IF YES, WHAT WAS DONE AND WHO PROVIDED THIS TREATMENT?
(INJECTIONS, THERAPY, TESTING, MRI, CT, MR ARTHROGRAM, XRAYS)

____

____

HAS SURGERY BEEN PERFORMED? YES NO

IF YES, WHO PERFORMED IT, AND WHEN, AND WHERE?

____

WHAT PROCEDURE WAS PERFORMED? ________________________________

WAS THIS PROCEDURE SUCCESSFUL? ________________________________