



9800 Broadway Extension, Oklahoma City, OK 73114 P:405.424.5426

How did you hear about our practice?

Please list referral name:

### PATIENT INFORMATION

(Please fill in all blanks)

Patient's Legal Name: Last		First		M.I.	Sex:	DOB:	Age:
Social Security Number:				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Patient's Address:				Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student <input type="checkbox"/> Retired			
City:	State:	Zip Code:	Email:		Referring Physician:		
Home Phone:	Work Phone:		Cell Phone:				
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Declined		Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Pacific <input type="checkbox"/> Native American <input type="checkbox"/> Multiple <input type="checkbox"/> Other			Preferred Language:		

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

Name of Primary Insurance Company	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	
Secondary Insurance (if applicable)	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

### EMPLOYMENT INFORMATION

Patient's Employer	Phone Number
Insured Employer	Phone Number

### If the patient is a minor, please list both parent names and employers

Mother	Employer	Phone Number
Father	Employer	Phone Number

### NEXT-OF-KIN INFORMATION

Nearest relative (or friend, not spouse), not living with you:	
Home Phone:	Relationship to Patient:

### THIRD PARTY BILLING (choose one)

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 hereby authorize my insurance 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 information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:
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Chart No. \_\_\_\_\_

## OKLAHOMA SPORTS SCIENCE & 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 voicemail 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 plans, 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 that this authorization will remain in effect until I revoke the authorization in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

OSSO STAFF ONLY

Documented by: Initials \_\_\_\_\_ Date \_\_\_\_\_



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### 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 and Orthopaedics, its agents and its 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 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)

\_\_\_\_\_  
(Relationship to patient) Policyholder's Signature \_\_\_\_\_

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made 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 healthcare 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 Dept. of Health, or by law.



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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) as your healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care.

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 405.424.5426 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 any FMLA, disability or accidental form completed. This charge is applicable per form completed any 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

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My signature below acknowledges receipt of this Financial Policy:

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(signature of person financially responsible for payment)

Relationship if other than patient \_\_\_\_\_

**PAUL JACOB, D.O.**  
**AGREEMENT FOR SHORT TERM NARCOTIC 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. This is to help both the patient and their provider comply with the law regarding post-surgery pain management. Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.*

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

**I agree to the following:**

1. I understand that as a surgical patient, I will receive narcotic pain medicine for a maximum of twelve (12) weeks post-surgery. If continued pain management is needed after this time, I will be referred to a pain management physician for further care.
2. 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.
3. 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.
4. 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.
5. I will not increase my medicine until I speak with my doctor or nurse.
6. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
7. 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.
8. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
9. I agree to come to the office for a pill count at any time if asked by my doctor.
10. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
11. 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 randomly through the course of my treatment.
12. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
13. I have been informed by my doctor 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.
14. I understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment such as an automobile.

**Refills**

1. 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.

2. I understand that refills will be made only during regular office hours: Monday through Thursday, 8:00AM-4:30 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 72 business hours is REQUIRED.
3. I must keep track of my medications. No early or emergency refills may be made.
4. 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.
5. 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 doctor 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.

### **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 notify my doctor. I am not to seek or accept medications from other providers without my doctor's permission, except in the event of a true medical emergency in which case, I must notify my doctor as soon as possible.

### **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 doctor may dismiss me as a patient of the practice and ask me to select another doctor. 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.

**72 HOURS NOTICE REQUIRED Initials:** \_\_\_\_\_

**NO REFILLS ON FRIDAY, SATURDAY, SUNDAY OR ON HOLIDAY REFILLS Initials:** \_\_\_\_\_

**DO NOT UNDER ANY CIRCUMSTANCES INCREASE YOUR MEDICATION DOSAGE WITHOUT DISCUSSING IT WITH THE OFFICE FIRST Initials:** \_\_\_\_\_

**DO NOT OBTAIN PAIN MEDICATION FROM ANY OTHER PHYSICIAN WITHOUT GETTING PERMISSION FROM DR. JACOB PRIOR. Initials:** \_\_\_\_\_

Patient's signature \_\_\_\_\_

Date \_\_\_\_\_

Physician'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. Paul Jacob 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 visit our website(s), [communityhospitalokc.com](http://communityhospitalokc.com) or [nwsurgicalokc.com](http://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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred PHARMACY NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ LOCATION: \_\_\_\_\_

Preferred MAIL ORDER PHARMACY NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

List all ALLERGIES to any medications, LATEX or TAPE and the reactions:

No Known Drug Allergies

Medication	Reaction

CURRENT MEDICATIONS: (Please include over the counter medications and food supplements.)

I DO NOT TAKE ANY MEDICATIONS ON A DAILY BASIS

1. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
2. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
3. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
4. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
5. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
6. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
7. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
8. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
9. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_
10. Drug Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How Often: \_\_\_\_\_

Please provide FIRST & LAST names of ALL other physicians that you currently see and their specialty:

1. \_\_\_\_\_ 4. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_

Have you used or are you currently using any of the following medications?

I CANNOT TAKE ANTI-INFLAMMATORIES (NSAIDS) Reason: \_\_\_\_\_

- Advil     Aleve     Aspirin     Arthrotec     Celebrex (celecoxib)     Diclofenac     Etodolac     Feldene  
 Flector Patch     Ibuprofen     Indocin     Ketorolac     Lodine     Meloxicam     Mobic     Motrin  
 Naprelan     Naprosyn     Naproxen Sodium     Pennsaid     Vimovo     Voltaren (oral or gel)     Zorvolex

Which of the following treatments have you attempted to treat your condition?

- Weight Loss     Physical Therapy/Exercise     Steroid Injections     Bracing     Use of cane/walker/crutches  
 Activity Modification    **LIST** activities you have trouble with: \_\_\_\_\_  
 Over the Counter/Prescription Medications    **LIST:** \_\_\_\_\_  
 Coxcomb injections (Synvisc, Orthovisc, Euflexa, Supartz, GelOne.....)