Personal / Family History

Please answer every question

Patient's Last Name _____ Patient's First Name _____

Patient's Date of Birth _____

Which hand is dominant? ❑ Ambidextrous ❑ Left ❑ Right

YOUR MEDICAL HISTORY

Please indicate if you have a history of the following:

- ❑ Chest Pain
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Reflux Esophagitis
- ❑ Chronic or Past GI Disorders
- ❑ Fibrocystic Disease
- ❑ Gout
- ❑ Eye/Vision Problems
- ❑ Glaucoma
- ❑ Ear, Nose, Throat Disorder
- ❑ Depression
- ❑ Head Injury
- ❑ Rheumatoid Arthritis
- ❑ Insulin Dependent
- ❑ Chronic or Past Head/Neck
- ❑ Seizure
- ❑ Sleep Apnea
- ❑ Neurologic Disease
- ❑ Other _____
- ❑ NONE
- ❑ Epilepsy
- ❑ Alzheimer's Disease
- ❑ Paralysis
- ❑ Osteoporosis
- ❑ MRSA Balance Problems
- ❑ Anemia
- ❑ Blood Clots
- ❑ Bleeding Problems
- ❑ Phlebitis
- ❑ Asthma
- ❑ Bronchitis
- ❑ COPD
- ❑ Pneumonia
- ❑ Emphysema
- ❑ Tuberculosis (TB)
- ❑ Shortness of Breath
- ❑ Peripheral Vascular Disease
- ❑ Stroke
- ❑ Do you have a Cardiologist? (*Whom*) _____
- ❑ Skin Disorders
- ❑ Chemotherapy/Radiation
- ❑ Heart Attack
- ❑ Congestive Heart Failure
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Chronic UTI
- ❑ Kidney Problems
- ❑ Kidney Stones
- ❑ Kidney Failure
- ❑ Dialysis
- ❑ Jaundice
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Immune System Disorder
- ❑ Lupus/SLE
- ❑ Diabetes
- ❑ Chronic or Past
- ❑ Cancer (*Type*) _____

FAMILY HISTORY

Please indicate if <u>YOUR FAMILY</u> has a history of the following.

If none, please mark "NONE". *(Only include parents, grandparents, siblings and children. Please list family member in space provided to the right).*

- ❑ Family History Unknown _____
- ❑ Bleeding Tendency _____
- ❑ Blood Clots _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Osteoarthritis _____
- ❑ Thyroid Disease _____
- ❑ Osteoporosis _____
- ❑ Lupus _____
- ❑ Heart Disease _____
- ❑ High Blood Pressure _____
- ❑ NONE _____
- ❑ Rheumatoid Arthritis _____
- ❑ Sjogren's Syndrome _____
- ❑ Heart Attack _____
- ❑ Ankylosing Spondylitis _____
- ❑ Sickle Cell Trait/Disease _____

SOCIAL HISTORY

If female, are you pregnant? ❑ Maybe ❑ Yes ❑ No

Do you live alone? ❑ Yes ❑ No

Have you had the pneumococcal vaccine? ❑ Yes ❑ No

Do you have a living will? ❑ Yes ❑ No

TOBACCO

What is your cigarette smoking status? ❑ Current (every day) ❑ Current (some days) ❑ Former ❑ Never

If you use other tobacco products (other than cigarettes), do you use: ❑ eCig ❑ Chewing Tobacco ❑ Cigar

ALCOHOL

Alcoholic drinks per day: ❑ Occasional ❑ 1 ❑ 2 ❑ 3 ❑ More than 3 ❑ None

DRUGS

Have you ever been addicted to or dependent on drugs or pain medication? ❑ Yes ❑ No

Are you currently using any street drugs? ❑ Yes ❑ No

EXERCISE

Type(s) of exercise: ❑ Bicycling ❑ Running ❑ Swimming ❑ Walking ❑ Aerobics ❑ Other

Times per week: ❑ Never ❑ Occasional ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7+

Patient's Last Name _____ Patient's First Name _____

Patient's Date of Birth _____

SURGERIES

Please indicate if you have had any of the following surgeries: (*Write date of surgery on the line.*)

❑ **I have had NO SURGERIES**

❑ Appendectomy _____
❑ Cardiac Bypass _____
❑ Cardiac Stent _____
❑ Implanted Defibrillator _____
❑ Pacemaker _____
❑ Heart Valve Implant _____
❑ Cataracts _____
❑ Fracture Repair _____
❑ Gallbladder _____
❑ Hernia _____
❑ Tonsillectomy _____
❑ Hysterectomy *(females only)* _____
❑ Kidney or/other Transplant _____
❑ Hip Replacement ❑ left ❑ right _____
❑ Knee Cartilage ❑ left ❑ right _____
❑ Knee Ligament ❑ left ❑ right _____
❑ Knee Replacement ❑ left ❑ right _____
❑ Shoulder ❑ left ❑ right _____
❑ Other: _____

Have you ever had an adverse reaction/problem with anesthesia? ❑ Yes ❑ No

If yes, please explain: _____

Have you had blood relatives with anesthesia problems? ❑ Yes ❑ No

If yes, please explain: _____

REVIEW OF SYSTEMS

Please check all the symptoms you are currently experiencing. If no symptoms, please check NONE.

GENERAL

❑ Fatigue ❑ Fever ❑ Chills ❑ Night Sweats ❑ Unexplained Weight Loss ❑ None

CARDIOVASCULAR

❑ Chest pain ❑ Swollen feet/legs ❑ Palpitations ❑ Difficulty breathing while lying in bed
❑ Pain in legs while walking ❑ Difficulty breathing on exertion ❑ None

ENDOCRINE

❑ Heat or cold intolerance ❑ Frequent urination ❑ Increased hat or glove sizes
❑ Sudden weight gain or loss ❑ Unusual changes in skin color ❑ High Blood Sugar
❑ Low Blood Sugar ❑ Excessive Thirst ❑ None

GASTROINTESTINAL

❑ Nausea ❑ Black or tarry stools ❑ Poor appetite ❑ Vomiting ❑ Hepatitis
❑ Abdominal pain ❑ Diarrhea ❑ Jaundice ❑ Heartburn or indigestion
❑ Bloody stools ❑ Gallstones ❑ Constipation ❑ None

GENITOURINARY

❑ Pain with urination ❑ Kidney stones ❑ Unusually frequent or urgent urination at night ❑ Incontinence
❑ Difficulty starting Urinary stream ❑ Flank or back pain ❑ Interrupted or weak urine stream
❑ None

HEMATOLOGIC

❑ Anemia ❑ Blood clots in legs ❑ Previous blood transfusions ❑ Enlarged Lymph nodes
❑ Tendency to bruise or bleed easily ❑ None

INTEGUMENTARY

❑ Itching or redness ❑ Sudden changes in moles or growths ❑ Rashes or spots ❑ Excessive sweating
❑ None

MUSCULOSKELETAL

❑ Joint stiffness ❑ Joint swelling ❑ Limited joint motion ❑ Muscle Pain ❑ None

NEUROLOGICAL

❑ Dizziness ❑ Fainting ❑ Hearing Problems ❑ Instability ❑ Stroke ❑ Memory loss ❑ Seizures
❑ Numbness and tingling ❑ Sudden weakness ❑ Unusual or severe headaches ❑ Tremors
❑ Visual Changes ❑ None

RESPIRATORY

❑ Cough ❑ Previous exposure to Tuberculosis (TB) ❑ Unusual shortness of breath ❑ Painful breathing
❑ Wheezing ❑ Coughing blood ❑ None

PSYCHIATRIC

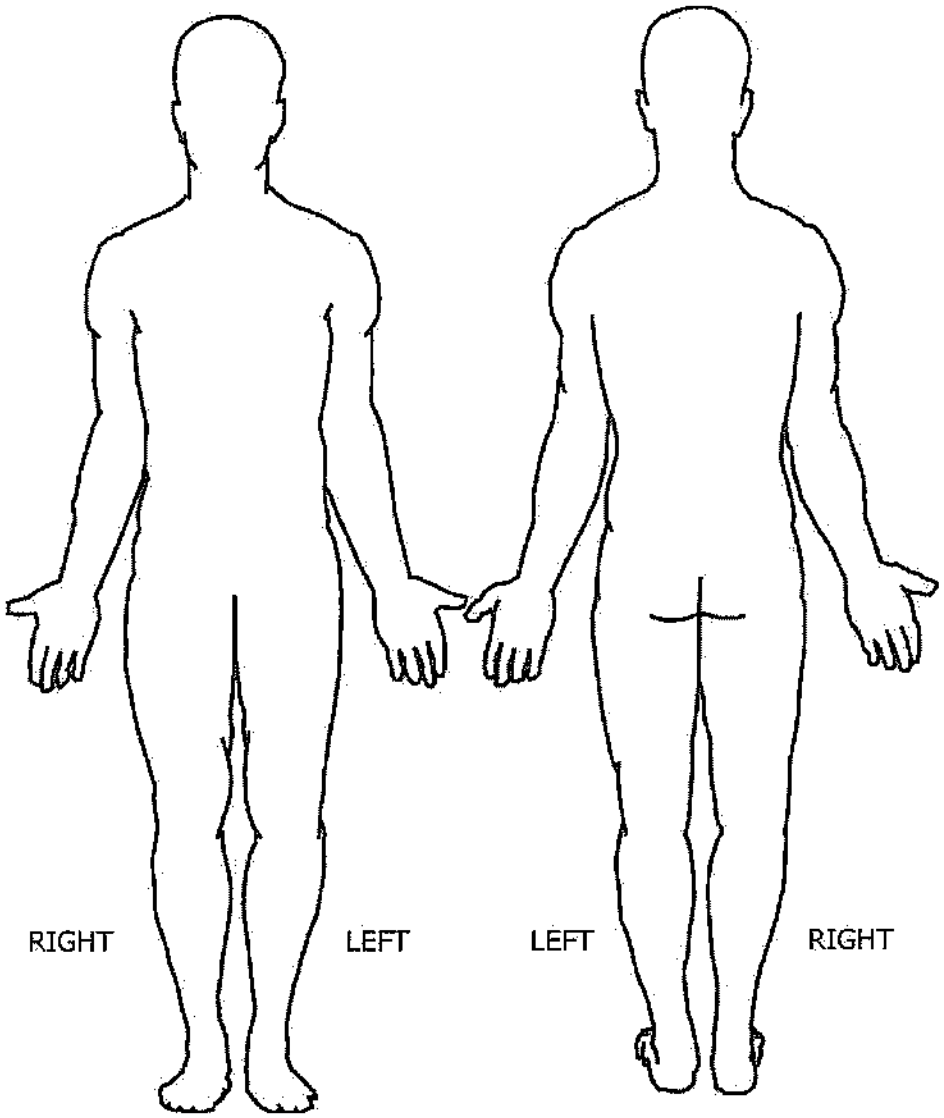
❑ Anxiety ❑ Depression ❑ Trouble Focusing ❑ Excessive Crying ❑ None

Patient Name: _____ Date: _____

Using the symbols below, please mark the areas where you feel the following sensations.

PLEASE PAY ATTENTION TO LEFT AND RIGHT SIDES.

Ache ^^^^^^^^^^ Numbness OOOOOOO Pins & Needles ======== Burning XXXXXXXX Stabbing ///////



HAVE YOU HAD ANY PREVIOUS INJURY(S) TO THE BODY PART(S) WE ARE SEEING YOU FOR TODAY? ☐ **YES** ☐ **NO**

I attest that the information stated on this document is true and correct to the best of my knowledge, and agree to contact and inform OSSO of any changes to the information stated herein.

X _____

Signature of patient or legal guardian (if not patient, please list your relationship to patient).

Medication and Allergy Information

Patient Name: _____

Medication	Strength and Frequency

Allergies:_____

_____

Pharmacy Information

Pharmacy Name:_____

Phone:_____ Fax:_____

Address:_____

_____

JEFFREY P. NEES, M.D.

3110 SW 89th Street, Suite 200E, OKC, OK 73159 – P: 405.486.6720 – F: 405.286.6485

PATIENT INFORMATION

(Please Print – Fill in All Blanks)

Patient's Legal Name: Last	First	M.I.	Sex:	DOB:	Age:

Social Security Number:	Marital Status: ____ Single _____ Married _____ Widowed _____ Divorced _____Separated
Patient's Address:	Employment Status: ____ Employed _____ Full-time student _____ Part-time student _____ Retired

City:	State:	Zip Code:	Referring Physician:	Primary Care Physician:
Home Phone:	Work Phone:		Cell Phone:	Email:

Ethnicity: ___Hispanic ___Non-Hispanic ___Declined	Race: __White __Asian __Black __Pacific __Native American __Multiple __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:

WHO REFERRED YOU TO OUR OFFICE? (circle one)

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

THIRD PARTY BILLING (circle 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/HPI Privacy Notice

Signature:	Date:

JEFFREY P. NEES, M.D.

3110 SW 89th Street, Suite 200E, OKC, OK 73159 – P: 405.486.6720 - F: 405.286.6485

Chart No. _____

HPI PHYSICIANS, LLC

Authorization to Release Information via Phone/Family/Friends

Patient Name:_____ DOB:_____

I hereby authorize confidential communications from the physicians or staff of OSSO and/or HPI Physicians 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

STAFF ONLY

Documented by: Initials _____ Date _____

JEFFREY P. NEES, M.D.

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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 & Orthopedics (OSSO) or HPI Physicians (HPI-P) 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 OSSO or HPI-P 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 OSSO or HPI-P 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 OSSO or HPI-P. 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 OSSO or HPI-P 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 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 or HPI PHYSICIANS, LLC

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 orthopedics, 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 405.427.3705 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/HPI-P 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. There is a $50.00 charge for any appointments not cancelled within 24 hours.

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_____

JEFFREY P. NEES, M.D.

3110 SW 89th Street, Suite 200E, OKC, OK 73159 – P: 405.486.6720 - F: 405.286.6485

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.

JEFFREY P. NEES, M.D.

3110 SW 89th Street, Suite 200E, OKC, OK 73159 – P: 405.486.6720 - F: 405.286.6485

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.

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-Thursday, 8:00 AM-4:00 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 _____