TCC

Runners Clinic

Thomas Coniglione, MD

Name________________________________Date________________

Email Address____

Date of Birth__________________________Age__________

Occupation____

Duration of Injury_____________________________________

How did the injury occur?____

____

Previous treatment for this injury?_____________________________________

____

Medical Conditions____

Number of Years Running____

Level of Running: _____Elite_____Collegiate_____High School

_____Recreational_____Recreational/Competitive

Running Surface:_____Track____Trail____Streets_____Other

Running Shoe Brand/Model__________________________________

Age of Running Shoes________________ Orthotics? Y / N

Other Brands you have used__________________________________

Number of Races in the last 6 months________Distances__________

Short Term Goals (< 3 Months)____

Long Term Goals (< 3 Months)____

Cross Training: Methods and Frequency______________________________________

____

Stretching (circle one): DAILY FREQUENTLY SOMETIMES NEVER

Name: ______________________ Date: __________

Are you here for a second opinion? ☐ Yes ☐ No

Date of Injury: ______________ Date Symptoms Began: ______________

Were you injured on the job? ☐ Yes ☐ No

If yes, how did injury happen ______________________

Where? ______________________ What time? __________

Have you been treated before for this injury? ☐ Yes ☐ No

Were x-rays or tests done? ☐ Yes ☐ No

Did you bring them or a report with you? ☐ Yes ☐ No

Able to continue activity or work: ☐ Yes ☐ No

If unable to work, please give date of last day worked ______________

Location of pain (i.e., shoulder, knee, etc.): ______________ Circle Lt. Rt.

Diagnosis given: ______________ Treatment given: ______________

Was surgery performed? ☐ Yes ☐ No (If so, please obtain operative report or notify the receptionist so she may obtain a copy for our records.)

Date of surgery: ______________ Surgery performed: ______________

List all previous surgeries (name and approximate date)

1. ______________ 2. ______________

3. ______________ 4. ______________

List any medications you are currently taking and how you take them.

1. ______________ 2. ______________

3. ______________ 4. ______________

Drug allergies? ☐ Yes ☐ No HEIGHT ________ WEIGHT ________

1. ______________ 2. ______________

3. ______________ 4. ______________

Have you ever had (Please circle Y for yes and N for no)?

Heart trouble, attack, angina	Y	N	High blood pressure	Y	N
Abnormal EKG	Y	N	Stroke	Y	N
Emphysema, other lung or breathing problems	Y	N	Jaundice, hepatitis, mono	Y	N
			Abnormal bleeding tendencies	Y	N
Epilepsy or seizures	Y	N	Blood disease (Anemia, etc.)	Y	N
Glaucoma	Y	N	Facial bone fractures	Y	N
Blood thinners	Y	N	Paralysis	Y	N
Kidney disease	Y	N	Diabetes	Y	N
Neck or back trouble	Y	N	Cancer	Y	N
Muscle weakness	Y	N	Positive HIV/Aids test	Y	N
Blood vessel disease	Y	N	Ulcers	Y	N
Arthritis	Y	N	Thyroid dx	Y	N
Do you smoke?	Y	N	Could you be pregnant?	Y	N

Packs/day ________

Signature ______________________

TCC

9800 Broadway Ext. • Oklahoma City, OK 73114 • Phone 405.427.6776

PATIENT INFORMATION

(Please Print – Fill In All Blanks)

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

ocial Security Number: | Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

atient's Address: | Employment Status: ____ Employed ____ Full-time student ____ Part-time student ____ Retired

ity: | State: | Zip Code: | Email: | Referring Physician:

ome Phone: | Work Phone: | Cell Phone:

thnicity: __Hispanic __Non-Hispanic __Declined | Race: __White __Asian __Black __Pacific __ Native American __Multiple __Other | Preferred Language:

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

lame of Primary Insurance Company

olicyholder Name | Relationship to Patient

olicyholder DOB | Policyholder SSN

olicyholder Employer

econdary Insurance (if applicable)

olicyholder Name | Relationship to Patient

olicyholder DOB | Policyholder SSN

olicyholder Employer

MPLOYMENT INFORMATION

atient's Employer | Phone Number

nsured Employer | Phone Number

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

lother | Employer | Phone Number

ather | Employer | Phone Number

EXT-OF-KIN INFORMATION

earest relative (or friend, not spouse), not living with you:

ome Phone: | Relationship to Patient:

VHO REFERRED YOU TO OUR OFFICE? (circle one)

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

HIRD PARTY BILLING (circle one)

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

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.

ignature: | Date:

Form 100

TCC

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 ________

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 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.

Oklahoma Sports Science & Orthopaedics

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 427-6776 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: ______________________________

Form 157

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. Thomas Coniglione 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

Dated: ________________________