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: _____ **Work**: _____ **Cell**: _____

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 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 SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including my information concerning identity, and release Oklahoma Sports Science & 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 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 or 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 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 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, pre-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 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 claims.

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 Master Card. 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 files 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: ____________________________________

Sheri M. Smith, M.D.

Orthopedic specialist for foot/ankle

Chief complaint/reason for visit summary

Patient name: _____ DOB_____ Date_____

- Who is your primary care physician?_____
- Who is your Cardiologist?_____
- Preferred pharmacy
  name_____

  Phone number_____

  Address/cross streets_____
- **Height_____ Weight_____**
- What body part/extremity are you being seen for today? RT/LT/BOTH _____
- How long have you had this injury? _____
- Is this injury a work-related injury? YES NO

  If Yes:

  date injury occurred_____ has a claim been filed for this injury? YES NO
- Is this injury due to a motor vehicle accident? YES NO

  If Yes:

  date injury occurred _____ Has a claim been filed for this injury YES NO
- Please describe how you sustained this injury

_____
_____
_____
_____

- Any other primary concerns you would like to discuss with Dr. Smith during your visit today?

_____
_____
_____
_____

Sheri M. Smith, M.D.

Orthopedic specialist for foot/ankle

Medical History Form

Review of systems

- **Are you experiencing any of the following symptoms:**

___Excessive weight gain/loss

___Dizziness

___Ringing in the ears

___Snoring

___Shortness of breath

___Chest pain

___Palpitations

___Anxiety

___Depression

___Headaches

___Seizures

___Syncope

___Heart attack

___Heart disease

___High blood pressure

___Atrial fibrillation

___Asthma

___COPD

___Emphysema

___Acne

___Rash

___Reflux

___Heartburn

___Ulcers

___Diverticulitis

___Liver disease

___Hepatic failure

___Arthritis

___Gout

___Broken bones

___Prostate issues

___Anemia

___Diabetes

__Type 1

__ Type II

__gestational

___Thyroid issues

___Stroke

___Headache

___Migraine

___Dementia

___Endometriosis

___HPV

___Cancer

Type_____

Social History

- Tobacco

  __Never

  __Former

  Date quit_____

  __Current

  __Light tobacco smoker

  __Heavy tobacco smoker

- Alcohol use: YES NO

  #drinks_____ per day /week /occasional *(Please circle one)*

- Occupation_____

Family History

Condition	**Family member**
Asthma	
Heart disease	
Heart failure	
High blood pressure	
Migraine	
Osteoporosis	
Stroke	
Thyroid issues	
Cancer:	
Other:	

Please list any radiology procedures (XRAYS, MRI, CT) specific to the reason you are here today

Type of procedure	**Date performed**

Allergies

List all allergies to any medications and the reactions

Latex allergy YES NO

Iodine or shellfish allergy YES NO

Medication	Reaction

Current medications

Drug Name:	Dose:	How often:

Past surgical history

- Please list **all** past surgeries

Surgery	Year

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 you responsibility to inform other physicians that we are prescribing and managing your 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, you 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 8:30am to 3:30pm 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 reported to the DEA, Police, and FDA.
- Lost, stolen, or misplaced prescriptions or medications ARE NEVER REPLACED - NO EXCEPTIONS. 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**

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

6205 North Santa Fe • Oklahoma City, Oklahoma 73118 • (405) 427-6776

J. Calvin Johnson, M.D. • Robert F. Hines, M.D. • Jimmy H. Conway, Jr., M.D. • Thomas Coniglione, M.D. • Robert S. Unsell, M.D. • Steve D. Coupens, M.D. • Michael H. Wright, M.D.
Arthur H. Conley, M.D. • Darryl D. Robinson, M.D. • Don E. Adams, M.D. • Hal D. Martin, D.O. • Barry L. Northcut, M.D. • Mac E. Moore, M.D. • Sheri M. Smith, M.D. • Ashley C. Cogar, M.D.

PATIENT INFORMATION

(Please Print - Fill In All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX	BIRTH DATE	AGE

SOCIAL SECURITY NO.:	E-MAIL ADDRESS:	MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

PATIENT'S ADDRESS:	Are You: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Not Employed ☐ Disabled

CITY:	STATE:	ZIP CODE:	PATIENT EMPLOYER:

HOME PHONE:	WORK PHONE:	CELL PHONE: Is it okay to leave a message on phone number provided? ☐ Yes ☐ No
( )	( )	( )

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

All policy holder informationmust be filled out completely in order to file your insurance.

Primary Insurance Company _____ Policy Holder _____

Employer_____ SS# _____ DOB _____

Secondary Insurance Company _____Policy Holder _____

Employer_____ SS# _____ DOB _____

Tertiary Insurance Company _____ Policy Holder _____

Employer_____ SS# _____ DOB _____

PERSON RESPONSIBLE FOR BILL

Name _____ DOB _____ SS# _____

Address_____ Phone# _____
(If different than patient)

WORK COMP / MVA Information -

Please note that if you answer yes to any of the following questions, we must have all the information prior to your appointment.

Is your injury work related?	☐ Yes	☐ No
Has a claim already been filed?	☐ Yes	☐ No
Is your injury due to a motor vehicle accident?	☐ Yes	☐ No

EMERGENCY CONTACT

HOME PHONE:	RELATIONSHIP TO THE PATIENT

I hereby authorize any insurance benefits to be paid directly to the facility and the physician and 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 and agree that I have received a copy of the TPG Privacy Notice.

Signature Date