# 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 (First and Last Name): | 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 |

## EMERGENCY CONTACT

| | |
|---|---|
| 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: |
|---|---|

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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 _____

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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

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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_____

**JEFFREY P. NEES, M.D.**

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# 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.**

OSSO
AN HPI AFFILIATE

**Jeffrey Nees, MD**
**3110 SW 89th Street, Suite 200E**
**Oklahoma City, OK 73159**
**P: 405.486.6720 F: 405.286.6485**

# Appointment No Show and Late Policy

## NO SHOW

- A NO SHOW appointment is a missed appointment without notifying our office prior to the scheduled appointment.
- If you do not show for your appointment, it is your responsibility to contact our office to be rescheduled.
- In the event there is a 3rd NO SHOW, this will result in immediate dismissal from the practice.

## LATE POLICY

We understand that the most punctual person can occasionally run late. If that is the case, we would greatly appreciate a call so that we may get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. If you do not call us prior to your appointment time, your appointment will be cancelled and result in a NO SHOW as mentioned above.

- Patients arriving early or on time will be seen in the order in which their appointment was scheduled.
- Post-operative patients arriving 15 minutes or later will be seen but will have to wait while we continue to see patients who have arrived to their scheduled appointment time.
- Non post-operative patients arriving 15 minutes or later will be asked to reschedule.

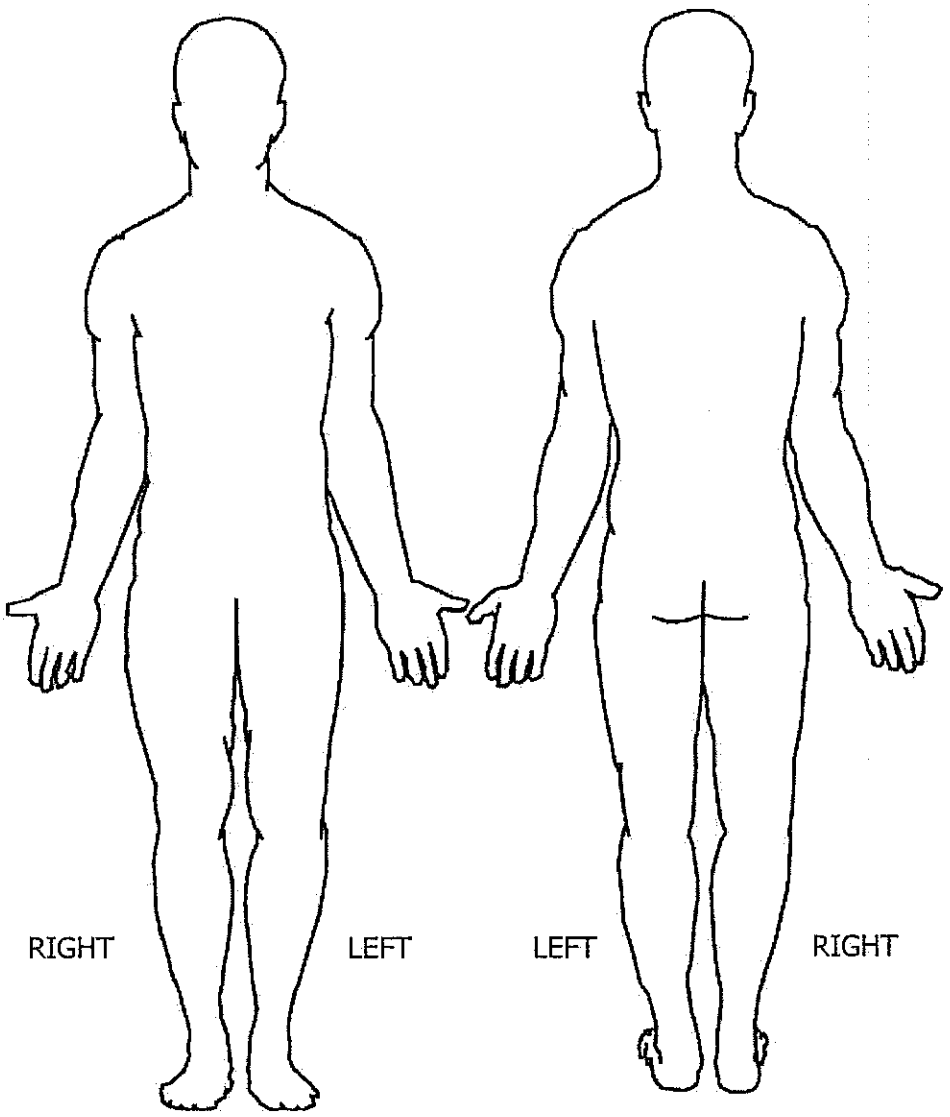
| | |
|---|---|
| Print Name | Print Name of Parent or Guardian (if applicable) |
| Signature of Patient | Signature of Parent or Guardian (if applicable) |
| Date | |

Patient Name: _____ DOB: _____ 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 and 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 Dr. Nees/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).

# PERSONAL & FAMILY HISTORY

Name: _____ DOB: _____

## MEDICAL HISTORY

Please indicate if you have a history of the following:

- ☐ NONE
- ☐ Anemia
- ☐ Asthma
- ☐ Alzheimer's
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer (type)_____
- ☐ Chest Pain
- ☐ Chemotherapy
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Dialysis
- ☐ Ear Nose Throat Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibrocystic Disease
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ GI Disorder
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Failure
- ☐ Kidney Problems
- ☐ Lupus
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Paralysis
- ☐ Peripheral Vascular Disease
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Radiation
- ☐ Reflux
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ UTI (chronic)
- ☐ Visual Impairment
- ☐ Other_____

Do you have a cardiologist? Whom_____
First and last name Location

## FAMILY HISTORY

Please indicate if **YOUR FAMILY** has history of the following:
****Only include parents, maternal or paternal grandparents, siblings and children)****

- ☐ FAMILY HISTORY UNKNOWN
- ☐ NONE
- ☐ Ankylosing Spondylitis_____
- ☐ Blood Clots_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Lupus_____
- ☐ Heart Attack_____
- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ Osteoporosis_____
- ☐ Rheumatoid Arthritis_____
- ☐ Sickle Cell Trait/Disease_____
- ☐ Sjogren's Syndrome_____
- ☐ Thyroid Disease_____
- ☐ Other_____

## SOCIAL HISTORY

If female, are you pregnant? ☐ Maybe ☐ Yes ☐ No
Have you had the pneumococcal vaccine? ☐ Yes ☐ No
Do you live alone? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No

## TOBACCO

Status: ☐ Currently (every day) ☐ Current (some days) ☐ Former ☐ Never
Type: ☐ cigarette ☐ eCig ☐ pipe ☐ cigar ☐ smokeless: snuff / chew

## ALCOHOL

Status: ☐ Yes ☐ No ☐ Never
How often: ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

## SUBSTANCE USE

Status: ☐ Yes ☐ No ☐ Never
Type:_____

## PHYSICAL ACTIVITY

(walking, running, jogging, dancing, swimming, biking, aerobics, cross fit, yoga, etc.)
☐ Never ☐ 1 day ☐ 2 day ☐ 3 day ☐ 4 day ☐ 5 day ☐ 6 day ☐ 7 day

Name: _____ DOB: _____

## SURGERY

Please indicate if you have had any of the following surgeries and the date of the procedure:

☐ NONE

☐ Appendectomy_____
☐ Back_____
☐ Cardiac Bypass_____
☐ Cardiac Defibrillator_____
☐ Cardiac Pacemaker_____
☐ Cardiac Stents_____
☐ Cataract Removal RIGHT / LEFT _____
☐ Gallbladder_____
☐ Gastric Bypass/Sleeve_____
☐ Hernia Repair_____
☐ Hip RIGHT / LEFT _____
☐ Hip Replacement RIGHT / LEFT _____
☐ Hysterectomy_____
☐ Kidney_____
☐ Knee RIGHT / LEFT _____
☐ Knee Replacement RIGHT / LEFT _____
☐ Neck_____
☐ Shoulder RIGHT / LEFT _____
☐ Shoulder Replacement RIGHT / LEFT _____
☐ Spinal Cord Stimulator_____
☐ Tonsillectomy_____
☐ Transplant_____
☐ OTHER_____

## REVIEW OF SYSTEMS

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

### GENERAL

☐ Chills ☐ Sweating ☐ Fatigue ☐ Fever ☐ Unexpected weight change ☐ NONE

### HENT

☐ Congestion ☐ Dental problems ☐ Hearing loss ☐ Nose bleeds ☐ Runny Nose ☐ Sinus pain
☐ Sinus pressure ☐ Ringing in ears ☐ Trouble swallowing ☐ NONE

### RESPIRATORY

☐ Apnea ☐ Chest tightness ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ NONE

### CARDIOVASCULAR

☐ Chest pain ☐ Leg swelling ☐ Palpitations ☐ NONE

### GASTROINTESTINAL

☐ Bloating/swelling ☐ Abdominal pain ☐ Anal bleeding ☐ Blood in stool ☐ Constipation
☐ Diarrhea ☐ Nausea ☐ Rectal pain ☐ Vomiting ☐ NONE

### ENDOCRINE

☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Excessive hunger ☐ Frequent urination ☐ NONE

### GENITOURINARY

☐ Difficulty urinating ☐ Painful urination ☐ Bedwetting ☐ Flank pain ☐ Frequent urination
☐ Genital sore ☐ Blood in urine ☐ Urgent urination ☐ Decreased urination ☐ NONE

### MUSCULOSKELETAL

☐ Joint pain ☐ Back pain ☐ Joint swelling ☐ Muscle pain ☐ Neck pain ☐ NONE

### SKIN

☐ Color change ☐ Paleness ☐ Rash ☐ Wound ☐ NONE

### NEUROLOGICAL

☐ Dizziness ☐ Headaches ☐ Light-headedness ☐ Numbness ☐ Seizures
☐ Loss of consciousness ☐ Tremors ☐ Weakness ☐ NONE

### HEMATOLOGIC

☐ Enlarged lymph nodes ☐ Bruises/bleeds easily ☐ NONE

### PSYCHIATRIC

☐ Agitation ☐ Behavior problems ☐ Confusion ☐ Decreased concentration
☐ Hallucinations ☐ Nervous/anxious ☐ Self-injury ☐ Suicidal thoughts ☐ NONE

OSSO

AN HPI AFFILIATE

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# MEDICATION & ALLERGY INFORMATION

Name: _____ DOB: _____

**ALLERGIES:** _____

**Have you ever had an adverse reaction/problem with anesthesia?** ☐ **Yes** ☐ **No**
**If yes, please explain:** _____

☐ **SEE ATTACHED LIST**

| MEDICATION | STRENGTH & FREQUENCY |
|---|---|
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| | |

Print Name: _____ Date of Birth: _____

All medications will be sent to pharmacies in electronic form **ONLY.**

If you need a refill, you will be required to contact our office
48 hours in advance since our physicians are not always in the clinic setting.
Same-day or next day refills **cannot** be guaranteed.

## WE DO NOT SEND PRESCRIPTIONS TO WAL-MART OR SAMS CLUB

Pharmacy Name: _____

Address / Major Cross Street(s): _____

City & State: _____

Phone Number: _____

**Please confirm the above information is correct.**
**This is where you will be required to pick up your prescription (s).**

Patient Signature: _____ Date: _____

## Dr. Jeffrey Nees / Koby Anderson PA-C

PATIENT/PROVIDER AGREEMENT
OPIOID PRESCRIPTIONS

Please review the information below and initial next to each item once you have reviewed and feel you understand and accept what each statement says.

| Patient Name: | DOB: |
|---|---|

| | |
|---|---|
| Your physician may prescribe you an opioid medication as part of your treatment plan. Your treatment plan may also include other care such as: physical therapy, therapeutic injections or surgery. | |
| This medication is used to help decrease and manage pain but may not take away your pain completely. | |
| This office prescribes opioid medications that will not be filled indefinitely. Your physician will taper your medications for discontinuation. Should you not be able to discontinue, you may be referred for long-term pain management. | |
| Once an opioid medication is prescribed, you will be required to have regular office visits to assess your pain and monitor your compliance with this agreement. **Your medication may not be refilled should you be unable to keep your regularly scheduled appointments.** | |
| It is your responsibility to notify us of any other physician who is prescribing you opioid medications. It is also your responsibility to inform that physician of the opioid medications you receive from us. | |
| Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines or other central nervous system depressants is highly dangerous and can be fatal. | |
| Opioid medications carry a high potential for abuse and addiction. Therefore, Federal and State laws carefully regulate dispensed opioid medications. **It is your responsibility to take the correct amount of medication during the allotted time. We will not refill your prescription should you run out earlier than anticipated.** | |
| When this medication is taken, it may not be safe to drive a car, operate machinery or take care of other people. You may also experience certain reactions or side effects such as: sleepiness/drowsiness, sleeping abnormalities, nausea, constipation, sweating, swelling, itching, allergic reactions, problems with thinking clearly, slowing of reactions or slowing of breathing. | |
| Individuals must be aware that "doctor shopping", excessive calls requiring medication and/or requests for increased dosage/frequency is viewed as narcotic drug seeking behavior and will not be tolerated. | |
| Lost, stolen or misplaced prescriptions ARE NEVER REPLACED – NO EXCEPTIONS. Your medications are your responsibility and should be stored correctly and safely disposed of should you no longer need them. | |
| Please do not call when you are completely out of medication. You may call up to 48 hours in advance for refills. Your physician may not be in the office every day and this time will allow for that. | |
| For females: please notify us immediately if you are pregnant or think you may be pregnant. | |

| Signature of Patient or Guardian: | Date: |
|---|---|
| | |