Calvin
JOHNSON, MD
Knees • Shoulders • Biologics
CalvinJohnsonMD.com

Thank you for scheduling with Dr. Calvin Johnson's office for your orthopedic needs. We would like to welcome you to our new facility. Dr. Johnson's strives for excellence in patient care and treats all patients like they are family. We would like to keep you informed of all clinic and office policies.

Doctor Johnson specializes in shoulders, knees and orthobiologic injections. Specifically ACL Reconstruction, Failed ACL Reconstruction with Anterolateral Ligament Reconstruction, Rotator Cuff Repair, Shoulder Stabilizations, Patellar Re-alignment, Biologic treatment for arthritis, and Biologic treatment in most joints.

A note from Dr. Johnson…….

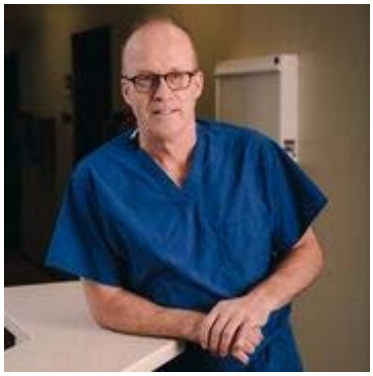
"In medicine, you-the patient, are my major motivational feature. As patients you entrust your safety and outcome to me." The privilege you give me to be your surgeon and operate on you when indicated is the most honorable position and responsibility a person can have.

I have THE BEST JOB in the world taking care of you and I DO NOT take this responsibility lightly. This is a lifelong passion and deliberate strategy to improve performance and gain excellent outcomes for you! I am relentless when it comes to helping you reach your goals!"

Sincerely,

Dr. James Calvin Johnson

Meet Dr. Johnson!!



Dr. James Calvin Johnson

Jeniffer, RMA 405-419-5645

James Calvin Johnson's mother worked as a surgical nurse during his childhood. Her passion for patient care and their wellbeing transcended and impacted Calvin tremendously. This passion for medicine and patient care lead Calvin to get a job as a teenager for the Ambulance Company in Bartlesville, Oklahoma.

Calvin Johnson graduated and completed his residency at The University of Oklahoma Medical School in 1984. His strong passion for sports medicine led him to specialize in orthopedic care to athletes and non-athletes alike. In 1994 Dr. Johnson founded OSSO (Oklahoma Sports and Science Orthopedics) which is dedicated to providing advanced orthopedic care to patients. Dr. Johnson has performed more than 20,000 arthroscopic knee and shoulder procedures for patients nationwide. He is also actively involved in research with Orthobiologics and minimally invasive treatment of osteoarthritis. Dr. Johnson is nationally known for his research lectures and has written over 20+ publications.

Favorite Quote: "If someone can't fix your problem…. Then their opinion doesn't count."- Coach Richard Gross

Patients Name: _____

Missed Appointment or No Show Appointment- In order to be respectful of the medical needs of other patients, please be courteous and call the Office promptly if you are unable to make your appointment by contacting the office **24 hours** in advance. There will not be a fee the first time you no show or late cancel your appointment. All instances thereafter will incur a $25.00 fee that will be added to your account and billed directly to you.

Initials _____

Medications- We ask that you call our office for any medication refills 24 hours prior to needing a refill. Please call our office directly at 405-419-5506. We ask that you contact the office 48 hours prior to needing the refill for all narcotic medications as a paper script will need to be picked up in person. Please note that there will not be any narcotic medication prescribed on Fridays after 3:00pm, weekends or holidays.

Initials _____

Narcotic Medication Refills- Narcotics will not be refilled past 6 weeks post op (from the date of your surgery). Should you be in need of more pain medication you will be referred back to your Primary Care Physician or a Pain Management Physician.

Initials_____

New Patients- To ensure a pleasant experience we try to expedite the processes that patients use while in our facility. In certain instances we ask that the patient help us in this regard. You will have x-rays at your initial visit, coming to your appointment in x-ray ready clothing (see below) alleviates the need to undress and re-dress, saving time for everyone. If those clothing types are not an option a dressing room and paper shorts/tops will be available. Please notify the medical staff if you are pregnant or believe you may be pregnant.

Initials_____

X-RAY attire recommended:

Patients being seen for their **knee or lower extremity** that need x-rays, if possible, dress in shorts or loose fitting pants that have **no metal (ex: snaps, buttons, zippers, and jewelry)** in the area to be x-rayed.

Patients being seen for their **shoulder or upper extremity** that need x-rays, please, remove any jewelry or metal from those areas. Plain shirts without metallic or jewel inlays are appropriate. Sports bras or bras without metal underwire in them are also preferred.

Hours:

Office

Monday – 8:00am to 5:00pm
Tuesday- 8:00am to 5:00pm
Wednesday- 8:00am to 5:00pm
Thursday- 8:00am to 5:00pm
Friday – 8:00 to 5:00pm

Surgery Days

Wednesday
Friday

Office Contacts:

Office FAX number: 405-419-5468
Scheduling Line: 405-419-5412

Answering Service After Hours- 405-703-0222

*****If you have a true medical emergency please call 911 or proceed to your nearest Emergency Room. You may also go to Community Hospital Emergency Room****

Community Hospital (South Campus Location)
3100 SW 89th Street
Oklahoma City, OK 73159
Phone: 405-602-8100

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)

_____ 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.

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. Calvin Johnson 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:_____

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

A DIVISION OF THE PHYSICIANS' GROUP

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, running injuries, 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 numbers 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 XXX-XXXX to make financial arrangements. Please be aware that charge 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, than 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_____

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

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 _____

OSSO
AN HPI AFFILIATE

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

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:	Email:	Referring Physician:

Home Phone:	Work Phone:	Cell Phone:

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 Privacy Notice.

Signature:	Date:

J. Calvin Johnson, M.D.

Patient Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Today's Pain Level on a scale of 0-10 _____

Please circle reason for today's visit: KNEE SHOULDER Please circle side: RIGHT LEFT BILATERAL

If you are a **NEW PATIENT** please complete the following questions:

Date of Injury: _____

Were you injured on the job? Yes No

Previous injury? Yes No

Occupation: _____ Choose one: Sedentary Light (10-20 lbs) Medium (25-50 lbs) Heavy (50+)

Are you currently able to work? Yes No If not, what is your last day worked? _____

Please list sports and recreational activities: _____

Allergies

No Known Allergies

Allergic to: _____

Medications

Please list all medications you are currently taken. Please continue on 2nd page if additional room needed.

NONE

Name of Medication	Strength (Mg, Mls, etc..)	Dosage (How many)	Frequency (Per hours/day)

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Please ensure all items are completed, then sign and date below.

_____ _____

Patient Signature Date