Oklahoma Sports Science and Orthopaedics, P.L.L.C.

OSSO Spine and Pain Management Center

3110 SW 89, Suite 102 • Oklahoma City, Oklahoma 73159

Arthur H. Conley, M.D. Phone: (405) 703-4900 • Fax: (405) 703-4960

Darryl D. Robinson, M.D. Phone: (405) 703-4950 • Fax: (405) 703-4955

New Patient Information

(Please Print - Fill in All Blanks)

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

SOCIAL SECURITY NO.:

MARITAL STATUS: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

PATIENT'S ADDRESS:

Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired

CITY:	STATE:	ZIP CODE:	REFERRING PHYSICIAN:

HOME PHONE:	WORK PHONE:	CELL PHONE:
( )	( )	( )

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

Name of the Primary Insurance Company ______________________________

Name of the Person who carries the Insurance Policy ______________ Relationship to Patient ______________

Carriers DOB ______________ Carriers SS# ______________

Carriers Employer ______________________________

Secondary Insurance ______________________________

Carrier Name ______________ Relationship to Patient______________

Not Applicable ❑ Carriers DOB ______________ Carriers SS#______________

Carriers Employer ______________________________

EMPLOYMENT INFORMATION

N/A ❑ Patients Employer ______________ Ph# ______________

N/A ❑ Insured Employer ______________ Ph# ______________

If the patient is a minor, please list both parents names and employer

Mother ______________ Employer ______________ Ph# ______________

N/A ❑ Father ______________ Employer ______________ Ph# ______________

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:

HOME PHONE:	RELATIONSHIP TO THE PATIENT:
( )	

WHO REFERRED YOU TO OUR OFFICE?

❑ Adjustor ❑ Attorney ❑ Billboard ❑ Case Manager ❑ Coach ❑ Doctor ❑ Employer ❑ Family ❑ Friend ❑ Hospital
❑ Insurance Co. ❑ Magazine ❑ Neighbor ❑ Newspaper ❑ Phone Book ❑ Physical Therapist ❑ Radio ❑ School ❑ Trainer

THIRD PARTY BILLING

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 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 ______________

Chart No. ________________________

Oklahoma Sports Science and Orthopaedics

Authorization to Release Information via Family/Friends

Patient Name: __________________________________ DOB: __________________

I hereby 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: __________________________

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 Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians', 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 Orthopedic & Sports Science Physicians'. 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 Orthopedic & Sports Science Physicians' 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 ____ **WITNESS TO SIGNATURE** ___________________

(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 a 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.

Date: ____________________

Patient: __________________ **Acct #:** ______________

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping
Print out this test, fill in your answers and see where you stand.

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score (add the scores up) (This is your Epworth score)	_____

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. Payments can be made by cash, check, money order, Visa, Discover Card or MasterCard. If you have a financial concern regarding your balance, please contact the Office Manager at 703-4905. 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. Not all of our physicians accept self pay accounts. Payment on self pay accounts is due at the time of service.

If your injury was due to a Motor Vehicle Accident, 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 St. Anthony North Ambulatory Surgery Center, Northwest Surgical Hospital, Community Hospital or Bone & Joint 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: ____

Print Name: ______________________________ Date: ________________________

Oklahoma Sports Science and Orthopaedics
Darryl D. Robinson, M.D.
Specializing in Comprehensive Pain Management & Non-Operative Spine Care
3110 SW 89th Street, Ste. 102
Oklahoma City, OK 73159
Phone: (405) 703-4950 Fax: (405) 703-4955

CONTROLLED SUBSTANCE/NARCOTIC PRESCRIPTION CONTRACT

Controlled substance medication (narcotics, opiods, tranquilizers, barbiturates) can be very useful to treat some painful conditions, but have high potential for misuse and abuse and are, therefore, closely controlled by the government. If used excessively the medications can cause adverse effects such as impaired judgment, vomiting, constipation, lethargy and even death.

To ensure that the medications are used properly to treat pain, each patient must agree to follow the instructions below. Patients who do not abide by the instructions and conditions of this contract and/or the treatment plan will be terminated from the practice. Patients must understand that a reduction of the intensity of pain and improvement of quality of life are the goals of this program.

Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.

1. I am responsible for my narcotic medications. If the prescription or the medication itself is lost, misplaced, stolen, or if I use my medication at a greater rate than prescribed, I will be without for a period of time. I understand that early refills are not given
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 the authorities (DEA, Police, etc…)
3. I understand that refills of narcotic medication will be made 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 script, I must call 48 hours in advance and leave a message on the nurse's line. If the prescription does not require a written script, I will call my pharmacy 48 hours in advance and have them fax the request to (405) 703-4955.
4. Refills for controlled substances will be possible by telephone Monday – Thursday 8:00 a.m. – 4:30 p.m. and Fridays 8:00 a.m. – 12:00 a.m. Refills for controlled substances will not be provided during non-office hours, holidays, or weekends. The answering service will not contact the doctor after hours regarding refills.
5. 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.
6. I will not request or accept narcotic medication from any other physician or individual while I am receiving such medications from this office, unless it is administered to me by a physician in an emergency room or hospital. If narcotic medication is prescribed by an emergency room physician, I will inform this office. In addition to being illegal to obtain narcotic prescriptions from multiple physicians, it may endanger my health. Any violation of this policy will be reported to the authorities and all physicians involved in my care.
7. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform such activity has been evaluated or I have not used the medication for at least four days.
8. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc…
9. I will not share, sell or trade my medication for money, goods or services of any kind.
10. I understand that I may be asked to submit to a drug test which will screen for illegal drug use and for the narcotics which I'm being prescribed. These drug screens may be given at my initial visit and randomly throughout the course of my treatment. If I refuse the test at any given time, I understand that I have chosen not to continue my treatment with Dr. Robinson and my treatment with Dr. Robinson will be discontinued immediately. In addition, should the results display any violation set forth in this contract, my treatment with Dr. Robinson may be immediately discontinued.

11. I understand it is against the law and will not attempt to get pain medication from any other health care provider without first telling them that I am taking pain medications provided by this office. If my primary care physician is willing to prescribe my medications, Dr. Robinson will have to approve the arrangements to avoid any duplication. I will discontinue all previously used pain medications unless otherwise directed by Dr. Robinson.
12. I understand that Dr. Robinson and/or his staff are able to pull my narcotic record from the Oklahoma Bureau of Narcotics secured web-site. This web-site tracks all narcotics I have received and details which doctor prescribed the narcotics and at what pharmacy they were distributed.
13. I agree to use ___________________________ (pharmacy name) located at ______________________________ (address). Telephone number: ____________________________
    If I change pharmacies for any reason, I will notify this office and will provide my previous pharmacy information to my new pharmacy. I authorize Dr. Robinson's office and my pharmacy to cooperate fully with any investigation regarding any possible misuse, sale, or other diversion of my pain medications. I authorize Dr. Robinson to provide a copy of this agreement to my pharmacy as necessary.
14. I have been informed by my physician about narcotic effects, including normal physiologic effect of tolerance (need for more medicine to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking the medication abruptly), and the abnormal effect of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain. Narcotics adversely affect my judgment in making business decisions and in operating equipment, such as an automobile.
15. 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, involving regular exercise, achieving optimal weight control, and limiting my use of unhealthy substances, such as smoking cigarettes and excessive alcohol. Cigarettes promote bone decay which can lead to deterioration of the vertebrae and discs, a major cause of spine pain. If I do smoke tobacco, in the interest of good health and to assist in pain control, I agree to quit smoking by three months from today. I understand that only by following a healthier lifestyle, I can hope to have the most successful outcome to my treatment.
16. I understand that this medication regime will be attempted for a period of two to four months. Within this period, my case 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 to my pre-trial medication and my care will be referred back to my primary care physician.
17. Non-payment of services rendered may result in your office visit being rescheduled. Per narcotic agreement refills will only be provided at your regularly scheduled office visit. If your office visit is rescheduled due to non-payment you will not receive a refill on your medications. The front desk will notify Dr. Robinson's team regarding your appointment being rescheduled. Someone from Dr. Robinson's team will contact you regarding your medications.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I UNDERSTAND, AND AGREE, THAT IF I VIOLATE ANY OF THE ABOVE INSTRUCTIONS AND CONDITIONS MY ENTIRE TREATMENT MAY BE TERMINATED. IF I DECLINE TO TAKE A URINE TEST (AT MY OWN EXPENSE) Y ENTIRE TREATMENT WILL BE TERMINATED. ANY VIOLATION OF THE 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.

_______________________________________ _________________________

Patient's Signature Date

Darryl Robinson, M.D.
Policies and Procedures

Thank you for the privilege to serve as your pain management physician. Dr. Robinson and his staff strive to provide the highest quality of medical care possible to all of our patients with professionalism and compassion. Please take a moment to review the policies of this office so that we may better serve you.

Scheduling: Office appointments and procedures are scheduled by Lindsay. If you need to schedule or check on a referral please call (405) 703-4950 and follow the prompts.

Cancellations: Please notify our office at least 24 hours prior to your scheduled appointment if you must cancel. Multiple cancellations, no shows or rescheduled appointments may be considered non-compliance and may result in termination from this practice.

Refills: State and Federal regulations require careful supervision of all prescribed medications, especially controlled substances (narcotics). Appointments must be scheduled with Dr. Robinson or Grant Roberts, PA-C to obtain medication refills. Refill approvals by phone or hand-written prescriptions are made only under special circumstances, providing a stable treatment plan has been established and followed and at the discretion of Dr. Robinson.

1. Refills are only given during regular office hours. Refills are not made on evenings, weekends, or holidays.
2. Refills will only be provided if the patient has a regular scheduled follow-up appointment with this office and the patient must be compliant with the current treatment plan.
3. Medication changes will not be made without prior approval from Dr. Robinson or his medical staff as no early refills will be provided.
4. All refill requests must be made 48 hours in advance to allow the staff and physician time to pull your chart and write the prescription.
5. Please do not leave more than one message as this will further delay your request.
6. Prescriptions may be picked up Monday – Thursday 8:00 a.m. – 4:30 p.m. and Fridays 8:00 a.m. – 12:00 p.m.
7. 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.
8. Patients are responsible for their medication. If any medication is lost, misplace, stolen or if the patient uses the medication in excess of the prescribed amount, the medication will not be replaced. Early refills will not be provided.
9. Patients must get their narcotic medications from only one pharmacy and prescribed by only one physician.

Emergencies: In the event of a new injury or a significant change in your condition, please call (405) 703-4950 and make an appointment. In the case of a true medical emergency during regular or after hours, 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 emergency room or another physician. **The patient must notify this office if narcotics have been obtained from another physician.**

Contracts: Our office observes the policy of presenting a narcotic contract to all patients who are prescribed narcotics. The narcotic contract is mandatory for all patients. Any violation of this contract will result in immediate termination from this practice. Please read the contract thoroughly and keep a copy for your records.

Courtesy: Dr. Robinson has a no tolerance policy for rude or discourteous behavior towards himself or any member of the staff in this office. Any violation of this policy will result in immediate termination from this practice. Likewise, we pledge to extend kindness and respect toward all of our patients.

Patient Signature: ____ Date: ___________________________

NEW PATIENT FORM FOR DR. DARRYL ROBINSON

Name____

Today's Date ____________________ **DOB:** _____________________ **Age** ____________________________

Who referred you? ____ **Fax #:** _________________________________

Primary Care Physician's Name____

Chief Complaint ____

Date of Injury or Onset of Pain (approximate) ____

Description of the Injury____

____

This Condition Is Related To: (circle one) Work, Motor Vehicle Accident, Sports Injury, Other ______________________

Present Treatment:

Please shade your areas of pain below:

Right Left Left Right

Medications that you currently take for pain:

_____________________ _____________________ _____________________

_____________________ _____________________ _____________________

Are your current medications helpful? Yes / No

Which physician prescribed it last? ______________________

Have you ever participated in Physical Therapy for this condition? Yes / No

When?____________________ Was Physical Therapy Helpful? Yes / No

Have you every had surgery for this condition? Yes / No Was surgery helpful? Yes / No

What surgery was performed? ____

Present Complaints:

Please rate your pain (circle a number below)

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Possible Pain

Describe the Pain: (circle all that apply)

Sharp Tender Burning Aching

Gnawing Stabbing Shooting Continuous

Intermittent

For Staff Only	
MRI/CT:	**Date(s):**
EMG:	**Date(s):**
Discogram:	**Dates(s):**
Injections:	**Date(s):**

Do you experience any NUMBNESS or TINGLING? (Please circle all that apply)

Arms Hands Fingers Hips Legs Feet Toes Other ________________________

Do you experience any WEAKNESS? Yes / No Where? ______________________

<u>Does anything make the pain BETTER</u>? (Please circle all that apply)

Sitting Standing Walking Bending forward/backward Coughing/sneezing Medication Exercise

<u>Does anything make the pain WORSE?</u> (Please circle all that apply)

Sitting Standing Walking Bending forward/backward Coughing/sneezing Medication Exercise

<u>Occupational History</u>

Current Occupation____

Occupation @ time of injury ____

Are you currently working? Yes / No If not, date last worked______________________________

Any Restrictions or TTD _____________________ if yes (list) _______________________________

<u>Medical History</u>

Current Medications not Related to Pain____

Allergies NKDA or ____

Surgeries____

Medical Illnesses____

<u>Review of Systems (circle all that apply)</u>

<u>Constitutional</u>
Fever
Chills
Night Sweats
Unexplained Wt Loss

<u>Neurological</u>
Headaches
Hearing Problems
Dizziness
Vision Problems

<u>Gastrointestinal</u>
Difficulty Swallowing
Stomach Pain
Nausea/Vomiting
Constipation/Diarrhea

<u>Skin</u>
Rash
Swollen Nodes

<u>Cardiopulmonary</u>
Chest Pain
Shortness of Breath
Cough
Swelling

<u>Psychiatric</u>
Depression
Alcohol/Substance

<u>Musculoskeletal</u>
Swollen Joints
Chronic Fatigue

<u>Genitourinary</u>
Urinary Problems
Sexual Difficulty

<u>Family History</u>

Cancer Arthritis Diabetes Lung Disease Kidney Disease Heart Disease

Liver Disease Muscle Disease Neurological Disease Hypertension Mental Illness

<u>Social History</u>

Single Married Divorced Separated Widowed

Children or Dependents **at home** (number, age) ____

Smoke/Tobacco YES / NO __________ Packs per day _____________ Years Alcohol YES / NO

<u>Are you presently involved in a lawsuit?</u> YES / NO **If yes, body part involved** __________________
(Related to Spine)

<u>Narcotic Agreement Signed</u> YES / NO **Drug Screen Completed** YES / NO
(For Staff Only) ***(For Staff Only)***

By Oklahoma Statute, we may charge you $1.00 for the first page and $.50 per page for each additional page. If your record contains any item that requires a photographic process to copy, such as a x-ray or photograph, we may charge you $5.00 per image.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our facility. To request an amendment, your request must be made in writing and submitted to the medical records office. In addition, you must provide a reason that supports your amendment request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by our facility
- Is not part of the information which you would be permitted to inspect or copy
- In our judgement is accurate and complete as it appears.
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of your medical information. To request this list of disclosures, you must submit in writing to Release of Information in our office. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. The first list you request within each 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected medical information we use or disclose about you for treatment, payment or healthcare operations. We must receive your restrictions in writing before we have made such disclosures. Also, if you restrict our right to use your protected medical information for treatment, payment or healthcare operations, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship. You have the right to request a limit on the protected medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

For example, you could ask that we not use or disclose information about a surgery to your family. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the receptionist in our facility. If you request restrictions, you must tell us what information you want to limit, whether you want to limit our use and/or disclosure and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or at home, or by mail, or by phone or by e-mail. To request confidential communications, you must make your request in writing to the receptionist in our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Copy of this Notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain the effective date.

COMPLAINTS

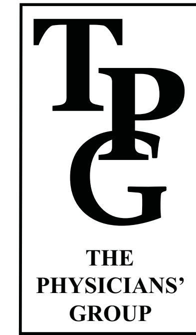
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our facility, please contact the Privacy Officer at (405) 419-8438. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of protected medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

Rev. 092404



Patient Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR RECEPTIONIST.

WHO WILL FOLLOW THIS NOTICE

This notice describes our facility's practices and that of:

- All employees, staff and other personnel
- Any health care professional authorized to enter information into your file or record
- All entities, sites and locations within ***The Physicians Group*** follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or healthcare operations purposes described in this notice.

Effective April 14, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Make sure that medical information that identifies you is kept private
- Follow the terms of the notice that is currently in effect
- Give you this notice of our legal duties and privacy practices with respect to protected medical information about you.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose protected medical information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use protected medical information about you for medical treatment or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists or other personnel who are involved in your care. Different departments of our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected medical information about you to people outside the practice who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.

For Payment: We may use and disclose protected medical information about you so that the treatment and services you receive may be billed to and payment may be collected for you, an insurance company or a third party. For example, we may need to give the information about the treatment you received to your health plan, so that your health plan will pay us or reimburse you. We may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We may use and disclose your information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your information to bill you directly for services and items.

Appointment Reminders: We may use and disclose protected medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected medical information to tell you about health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release protected medical information about you to a designated friend or family member who is involved in your medical care. We may give information to someone who helps pay for your care. In addition, we may disclose protected medical information about you to an entity assisting in a disaster relief effort, so that your family can be notified about your condition, status or location.

Research: Under certain circumstances, we may use and disclose protected medical information about you for research purposes. All research projects are subject to a special approval process. The process evaluates a proposed research project and its use of your information, trying to balance the research needs with patients need for privacy of their medical information. However, we may disclose medical information about you to people preparing to conduct a research project, though we will ask for your specific permission to give a researcher your name, address or other information that reveals your identity. In rare cases, your permission may be waived as directed by federal, state and local law.

As Required by Law: We will disclose protected medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may need to use and disclose protected medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release protected medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority, if you are in their service.

Workers' Compensation: We may release protected medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. State and/or federal law control release of such information.

Public Health Risks: We may disclose protected medical information about you for public health activities. These activities include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report a known or suspected crime
- To report child abuse or neglect
- To report vulnerable adult abuse
- To report reactions to medications or problems with products
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of domestic violence. We will only make this disclosure if you agree or when required or authorized by law

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- About a death we believe may be the result of criminal conduct
- About criminal conduct involving our facility
- About the victim of a crime, if we are unable to obtain the person's agreement
- In emergency circumstances to report a crime, the location of the crime or victims and/or the identity, description or location of the person who committed the crime

Medical Examiners and Funeral Directors: We may release protected medical information to a medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security, Intelligence and Federal Protective Service Activities: We may also release protected medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may release information to authorized federal officials where required to provide protection to the President of the United States, other authorized persons or foreign heads of state and/or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected medical information about you to the correctional institution or law enforcement official. The release of this information would be necessary for this practice to provide you with healthcare, to protect your health and safety or the health and safety of others and for the security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding protected medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect and/or copy your medical information you must submit your request to Release of Information in our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

PRIOR TO YOUR INJECTION OR PROCEDURE

You must stop the following medications 5 days prior to your injection

MOBIC (MELOXICAM)
RELAFEN
VOLTAREN
IBUPROFEN
MORTIN
KETOPROFEN
COMBUNOX
NAPROSYN
ALEVE
DICLOFENAC
ARTHROTEC
SULINDAC
INDOMETHACIN
TOLMETIN
LODINE
ETODOLAC
PRIOXICAM/FELDENE
SOMA COMPOUND
COUMADIN
WARFARIN
ASPIRIN
PLAVIX
PLETAL
OR ANY OTHER ANTI-INFLAMMATORIES
OR ANY OTHER BLOOD THINNERS

YOU MUST HAVE APPROVAL TO STOP YOUR BLOOD THINNER FROM THE PHYSICIAN WRITING IT

- If you are taking **CELEBREX** you do not have to stop taking it prior to your injection.
- Nothing to eat or drink 4 hours prior to your procedure.
- You may take any pain medication (**unless it has an anti-inflammatory in it**), heart medication, blood pressure, or thyroid medication with a sip of water the morning of your procedure.
- For Discograms lab work must be done 3 days prior to your procedure.
- If you are a diabetic and take oral medication do not take any the day of your procedure. If you use insulin and your procedure is in the morning you can take half of your long acting dose (**no quick acting**), if your procedure is in the afternoon do not take any insulin.
- You must have an adult driver to take you home after your procedure or your procedure will be cancelled.

****WE REQUIRE A 24-HOUR CANCELLATION NOTICE PRIOR TO YOUR PROCEDURE. IF YOU FAIL TO*** CONTACT OUR OFFICE WITHIN 24 HOURS YOU WILL BE CHARGED A $200.00 FEE.

***Patient Signature:*____________________________________*Date:*____________________**

Oklahoma Sports Science and Orthopaedics

Patient Name______________________________
DOB________________
Date________________

Name of the physician you are seeing here today________________________________

How did you hear about our office? (please circle)

Athletic Trainer Attorney Coach Workers Comp Adjuster Workers Comp Case Manager Employer Friend Family Hospital Insurance Co Magazine Phone Book Radio Television School Doctor

Did an athletic trainer refer you to us? Yes No
If so please list their name and the school you attend

Name____
School____

Who is your Family Physician?

Name____
Phone____

Did your Family Physician refer you to us? Yes No

Did another Physician refer you to us? Yes No
If so please list their name and phone number

Name____
Phone____

If you are seeing us due to a Workers Comp Injury do you have a Case Manager assigned to your case? If so please list their name and phone number

Name____
Phone ____