

**Daron C. Hitt M.D.**

**Hand & Plastic Surgery**

**3110 S.W. 89<sup>th</sup> Street Suite 200 A-B Oklahoma City, OK 73159 – PH 405-486-6800 – Fax 405-426-6441**

**PATIENT INFORMATION**

Date	Referring Physician		Referring Physician Phone	
Last	First	Middle	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Address	City	State	Zip	
SSN:	Age	DOB:	Marital Status: S M W D DEP	Employed: Yes No
Employer/School	Address	City	State	Zip
Home Phone:	Cell Phone	Other:	E-Mail:	

**EMERGENCY CONTACT/NEAREST RELATIVE NOT LIVING WITH YOU**

Name	Relation to Patient	DOB:
Telephone Number:		

**INSURANCE INFORMATION (Provide cards to copy)**

Is Your Injury Work Related? YES NO	Is This Injury Due to a Motor Vehicle Accident? YES NO		
Primary Insurance:	Insurance Type Group _____ Individual _____ COBRA _____		
Address	City	State	Zip
Insured's Name on Card	ID#	Group#:	
Insured's DOB	Relation to Insured	Insured Sex M _____ F _____	Insured SS#
Insured's Employer	Insured's Phone		

Secondary Insurance	Insurance Type Group _____ Individual _____ COBRA _____		
Address	City	State	Zip
Insured's Name on Card	ID#	Group#	
Insured's DOB	Relation to Insured	Insured Sex M _____ F _____	Insured SS#
Insured's Employer	Insured's Phone		

**OTHER INFORMATION**

I hereby authorize my insurance benefits 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 and agree that I have received a copy of the HPI/TPG Privacy Notice.

\_\_\_\_\_  
Patient or Authorized Person

\_\_\_\_\_  
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', 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 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  
(NEAREST RELATIVE OR TO SIGNATURE  
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 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.

**Daron C. Hitt M.D**  
**Hand Surgery**  
An HPI Affiliate

**Financial Policy**

*Thank you for choosing Dr. Daron Hitt as your healthcare provider. We are dedicated to providing the highest quality, most cost effective care specializing in Reconstructive & Orthopedic 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 provider's 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 authorizations 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 and coverage.**

Accurate, up to date information in 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 claims.

Payment for all co-insurance, deductible and non-covered services is due at the time of service. Payments can be made by cash, check, money order, and Visa, Discover Card, American Express or MasterCard. If you have financial concern regarding your balance, please contact our billing office at (405) 419-8444. Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, emergency surgery facilities and some radiology services may be billed separately. Not all of our physicians except self pay accounts. Payment on self pay accounts are due at time of service.

If your injury was due to a Motor Vehicle Accident, you will be set up on a self pay account for any charges incurred up to \$500.00. If charges exceed \$500.00, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order ensure payment to the Physician.

There is a \$25.00 charge for FMLA, disability or accidental forms 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 Northwest Surgical Hospital or Community 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 us to participate in your care.

Sincerely,

Daron Hitt M.D. and Staff

My signature below acknowledges receipt of this financial policy:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of person financially responsible for any bills.)

Relationship if other than patient: \_\_\_\_\_

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Hand & Plastic Surgery

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## REQUEST TO RESTRICT MANNER & METHOD OF CONFIDENTIAL COMMUNICATING

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_

PATIENT TELEPHONE: \_\_\_\_\_

I hereby request to receive confidential communications from HPI regarding my health condition, care, treatment, appointments, and/or payment in the following manner and method.

**(Please check all that apply)**

\_\_\_\_\_ At a telephone number other than my home number. Alternate number is:

\_\_\_\_\_

\_\_\_\_\_ At a mailing address other than my home address. Alternate address is:

\_\_\_\_\_

\_\_\_\_\_ Via email. The alternate email is: \_\_\_\_\_

\_\_\_\_\_ The following individuals may pick up my prescriptions, samples, appointment info, and records:

\_\_\_\_\_

\_\_\_\_\_ Messages may be left concerning my care on the answering machines, voicemail, or with the following individuals: \_\_\_\_\_

I understand that, if HPI agrees to provide with my confidential communications regarding my health care via the above identified alternate manner and method, HPI may condition his/her agreement upon the following:

1. The receipt of information from me as to how payment for HPI services will be handled.
2. The specification of an alternative address or other method of contact.

PATINET  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## DARON C. HITT M.D.

### OPIOID CONSENT FORM

Instructions: Please review the information listed below and put your Initials next to each item when you have reviewed it with your provider and feel you understand and accept what each statement says.

Patient Name:	Date of Birth:
	Initials
My surgeon will prescribe an opioid medication to help me control and manage post-surgical pain.	
This medicine is to be used to decrease and manage my pain but will not take away my pain completely.	
I will stop using the opioid medicine as soon as my pain is manageable and will use over the counter pain relievers if possible to manage the pain.	
I will contact my provider if the medicine does not control my pain when I take it as prescribed or if I have any adverse reactions to it.	
I will follow-up with my provider for post-surgical consultations as instructed or requested by my provider.	
If I do not use all of the medicine prescribed, I will ensure that it is disposed of properly in order to prevent its misuse by someone else.	
I will safely store the medicine to minimize that children or other people will NOT take it.	
When I take this medicine it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.	
When I take this medication, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.	
I may become physically or psychologically dependent or addicted to this medicine if I take them continuously so I agree to stop using them at the earliest possible time and to take no more than is necessary to control my pain.	
I will tell my provider if I or anyone in my family has had any problems with mental illness or with controlling drug or alcohol use in the past.	
Taking too much of my pain medication, or mixing my pain medications with drugs, alcohol, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.	
It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medications that may interact dangerously with my pain medications.	
I will not use any illegal substances, such as cocaine, etc., while taking this medicine.	
If I travel out of the country while taking this medicine, I will notify the appropriate travel authority (usually the consulate website of the country) and obtain a note from my provider before travel, as traveling out of country with opioids may pose problems.	
For females: I understand it is my responsibility to inform my provider if I am pregnant	

Signature of Patient or guardian	Date:
Printed name of patient or guardian:	

**Daron Hitt M.D.**

3110 S.W. 89<sup>th</sup> Street, Suite 200 A-B  
Oklahoma City, OK 73159

Phone: 405-486-6800  
Fax: 405-426-6441

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**CONFIDENTIAL MEDICAL HISTORY**

Hand Dominance:  Left  Right  Ambidextrous

Current Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Current Weight: \_\_\_\_\_ lbs.

What is the reason for your visit today? \_\_\_\_\_

Is this work related?  Yes  No Is this related to a car accident?  Yes  No DOI: \_\_\_\_\_

How long have you had symptoms? \_\_\_\_\_ Have you had similar problems in past?  Yes  No

If yes, explain: \_\_\_\_\_

**STUDIES AND TREATMENT**

Please check any treatment(s) you have had:

- Activity Modification
- Splints, Braces, Wraps
- Medications
- Therapy

Please check any studies, include date:

- X-Ray \_\_\_\_\_
- MRI/CT \_\_\_\_\_
- EMG \_\_\_\_\_

**LOCATION OF PROBLEM**

ELBOW	WRIST	HAND	THUMB	INDEX	MIDDLE	RING	SMALL
<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R

**PAIN/COMPLAINTS**

Pain level \_\_\_\_\_ /10

- sharp  stabbing  aching  throbbing  burning  shooting
- numbness  tingling  Other: \_\_\_\_\_

**ALLERGIES:**

No Known Allergies

Medications \_\_\_\_\_

Shellfish  Contrast Dye  Latex  General/Local Anesthesia

**PHARMACY**

NAME	ADDRESS	PHONE NUMBER
_____	_____	_____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**CURRENT MEDICATIONS:**

No Current Medications

Name Dose/Frequency

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Are you on any blood thinners?  Y  N

**MEDICAL CONDITIONS:** To the best of your knowledge, have you ever had a medical problem related to the following?

Skin Rashes or disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Ear, Nose, Throat	<input type="checkbox"/> Y <input type="checkbox"/> N
Bladder or kidneys	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Stomach	<input type="checkbox"/> Y <input type="checkbox"/> N
Lung disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	Gallbladder	<input type="checkbox"/> Y <input type="checkbox"/> N
Thyroid	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Prostate	<input type="checkbox"/> Y <input type="checkbox"/> N
HIV, Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N				

NONE OF THE ABOVE

**PAST SURGERIES:**

NO past surgeries

Operation Surgeon Year

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**FAMILY HISTORY:**

Family History Unknown

Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Whom:	_____
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Whom:	_____
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Whom:	_____
Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Whom:	_____
Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	Whom:	_____
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Whom:	_____

**SOCIAL/PERSONAL HISTORY:**

Do you smoke tobacco products?  Y  N If yes, \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Are you a former smoker?  Y  N

Do you use smokeless tobacco?  Y  N

Any history of substance abuse?  Y  N

How often do you drink alcohol?  Daily  Occasionally  Never

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please check any of the following that you have experienced within the last 3 months or are experiencing now.

- |  |  |  |  |   |
|--|--|--|--|---|
| <input type="checkbox"/> Joint Pain        | <input type="checkbox"/> Joint Stiffness   | <input type="checkbox"/> Joint Swelling      | <input type="checkbox"/> Instability           | <input type="checkbox"/> Redness            |
| <input type="checkbox"/> Heat              | <input type="checkbox"/> Muscle pain       | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Tingling              | <input type="checkbox"/> Muscle Weakness    |
| <input type="checkbox"/> Weight loss       | <input type="checkbox"/> Weight gain       | <input type="checkbox"/> Fever               | <input type="checkbox"/> Chills                | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Rashes            | <input type="checkbox"/> Poor healing      | <input type="checkbox"/> Skin Ulcer          | <input type="checkbox"/> Mass                  | <input type="checkbox"/> Pigmentary change  |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Easy bruising     | <input type="checkbox"/> Excessive bleeding  |  |   |
| <input type="checkbox"/> Corrective Lens   | <input type="checkbox"/> Visual changes    | <input type="checkbox"/> Watering            | <input type="checkbox"/> Eye Pain              | <input type="checkbox"/> Blur/Double vision |
| <input type="checkbox"/> Wheezing          | <input type="checkbox"/> Cough             | <input type="checkbox"/> Shortness of breath |  |   |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Murmur            | <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Irregular heartbeat   |   |
| <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Nausea            | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Reflux                | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Bloody Stool      | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> Urinary Frequency     |   |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Urinary Frequency |  |  |   |
| <input type="checkbox"/> Nose bleeds       | <input type="checkbox"/> Bleeding gums     | <input type="checkbox"/> Ear ache            | <input type="checkbox"/> Difficulty swallowing |   |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Depression        | <input type="checkbox"/> Sleep Difficulties  |  |   |
| <input type="checkbox"/> NONE OF THE ABOVE |  |  |  |   |



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### EMPLOYMENT HISTORY

Please answer the following questions:

#### OCCUPATIONAL HISTORY:

Date last worked: \_\_\_\_\_

Current work status: \_\_\_\_\_ TTD  
\_\_\_\_\_ Restricted Duty  
\_\_\_\_\_ Full Duty

Jobs held in the past five years:

	Job Title	Employer	From (month/year)	To (month/year)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

#### JOB DESCRIPTION:

When injury occurred, how many hours did you work, per day? \_\_\_\_\_ per week? \_\_\_\_\_  
Overtime? \_\_\_\_\_ Occupation at the time of the injury? \_\_\_\_\_

List of job duties and physical requirements of your work at the time of the injury \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Work activities performed: Mark your usual work duties (at the time of injury) with the following letters:

N= Not at all

O= Occasionally

F= Frequently

C= Constantly

\_\_\_ Stand

\_\_\_ Push

\_\_\_ Drive vehicle

\_\_\_ a. 10 lbs or less

\_\_\_ Walk

\_\_\_ Pull

\_\_\_ Overhead work

\_\_\_ b. 11 to 25 lbs

\_\_\_ Climb

\_\_\_ Reach

\_\_\_ Lift 

\_\_\_ c. 26 to 50 lbs

\_\_\_ Squat

\_\_\_ Twist

\_\_\_ d. 51 to 75 lbs

\_\_\_ Kneel

\_\_\_ Bend

\_\_\_ e. over 100 lbs

\_\_\_ Stoop

\_\_\_ Detailed hand work

\_\_\_ f. with assistance?

Total years performed this type of work? \_\_\_\_\_

Total number of years worked for employer at the time of injury? \_\_\_\_\_

Date of hire? \_\_\_\_\_

Work activities performed on present occupation (if different than listed on page 1). Mark your usual work duties with the following letters:

N= Not at all


O= Occasionally

F= Frequently

C= Constantly

Stand  
 Walk  
 Climb  
 Squat  
 Kneel  
 Stoop

Push  
 Pull  
 Reach  
 Twist  
 Bend  
 Detailed hand work

Drive vehicle  
 Overhead work  
 Lift 

a. 10 lbs or less  
 b. 11 to 25 lbs  
 c. 26 to 50 lbs  
 d. 51 to 75 lbs  
 e. over 100 lbs  
 f. with assistance?

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Total number of years performed at this type of work: \_\_\_\_\_

*I certify that the above information is true and correct to the best of my knowledge. I understand it is important and necessary to give correct information for proper medical evaluation.*

\_\_\_\_\_  
Patient's printed name

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

# WORKERS' COMPENSATION

## Examination Questionnaire

Please answer the following questions:

- 1) Name \_\_\_\_\_ Date of Injury \_\_\_\_\_ Is the injury work related? \_\_\_\_\_ If so, please explain: \_\_\_\_\_
- 2) Are you currently working: \_\_\_\_\_ if no, please explain: \_\_\_\_\_
- 3) Are you able to work? \_\_\_\_\_ If no, please explain: \_\_\_\_\_
- 4) Prior to the injury, what activities or hobbies did you participate in? \_\_\_\_\_
- 5) Have you been able to participate in these activities or hobbies since your injury occurred? \_\_\_\_\_ If not, why? \_\_\_\_\_
- 6) What can't you do now that you were able to do prior to your injury? \_\_\_\_\_
- 7) List body parts injured (please be specific): \_\_\_\_\_
- 8) Please list the limitations for each injured body part: \_\_\_\_\_
- 9) Physician's comments: \_\_\_\_\_

*I certify that the above information is true and correct to the best of my knowledge. I understand it is important and necessary to give correct information for proper medical evaluation.*

\_\_\_\_\_  
Patient's printed name

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date