Daron C. Hitt M.D.

Hand & Plastic Surgery

3110 S.W. 89th 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: ___M ___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', 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.

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: _____

Daron C. Hitt

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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:	

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Name: _____ **DOB:** _____ **Today's Date:** _____

CONFIDENTAL 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
□ L □ R	□ L □ R	□ L □ R	□ L □ R	□ L □ R	□ L □ R	□ L □ R	□ L □ 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

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	□ Y □ N	Osteoporosis	□ Y □ N	Ear, Nose, Throat	□ Y □ N
Bladder or kidneys	□ Y □ N	Epilepsy	□ Y □ N	Stomach	□ Y □ N
Lung disease	□ Y □ N	Stroke	□ Y □ N	Gallbladder	□ Y □ N
Thyroid	□ Y □ N	Hypertension	□ Y □ N	Prostate	□ Y □ N
HIV, Hepatitis	□ Y □ N	Cancer	□ Y □ N	Heart Attack	□ Y □ N
Blood Disorder	□ Y □ N	Diabetes	□ Y □ N	Seizures	□ Y □ N
Sleep Apnea	□ Y □ N				

□ NONE OF THE ABOVE

PAST SURGERIES: □ NO past surgeries

Operation	Surgeon	Year

FAMILY HISTORY: □ Family History Unknown

Arthritis	□ Y □ N	Whom: _____
Cancer	□ Y □ N	Whom: _____
Diabetes	□ Y □ N	Whom: _____
Heart disease	□ Y □ N	Whom: _____
Stroke	□ Y □ N	Whom: _____
Hypertension	□ Y □ 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.

☐ Joint Pain	☐ Joint Stiffness	☐ Joint Swelling	☐ Instability	☐ Redness
☐ Heat	☐ Muscle pain	☐ Numbness	☐ Tingling	☐ Muscle Weakness
☐ Weight loss	☐ Weight gain	☐ Fever	☐ Chills	☐ Night Sweats
☐ Rashes	☐ Poor healing	☐ Skin Ulcer	☐ Mass	☐ Pigmentary change
☐ Anemia	☐ Easy bruising	☐ Excessive bleeding		
☐ Corrective Lens	☐ Visual changes	☐ Watering	☐ Eye Pain	☐ Blur/Double vision
☐ Wheezing	☐ Cough	☐ Shortness of breath		
☐ Chest pain	☐ Murmur	☐ Palpitations	☐ Irregular heartbeat	
☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Reflux	☐ Constipation
☐ Diarrhea	☐ Bloody Stool	☐ Incontinence	☐ Urinary Frequency	
☐ Painful Urination	☐ Urinary Frequency			
☐ Nose bleeds	☐ Bleeding gums	☐ Ear ache	☐ Difficulty swallowing	
☐ Anxiety	☐ Depression	☐ Sleep Difficulties		

☐ NONE OF THE ABOVE