DARON C. HITT, M.D.
HPI Physicians, LLC
3115 SW 89th Street, OKC, OK 73159 P: 405.486.6800 / F: 405.426.6441

PATIENT INFORMATION (PLEASE Print – Fill In All Blanks)

Patient's Legal Name: Last First M.I	Sex:	DOB:	Age:

Social Security Number:	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Patient's Address:	Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Retired

City:	State:	Zip Code:	Referring Physician:	Primary Care Physician:

Home Phone:	Work Phone:	Cell Phone:	Email: ☐ Patient Declined

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline	Race: ☐White ☐Asian ☐Black ☐Native American ☐Pacific ☐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:
Name of **Secondary** Insurance: (if applicable)		
Policyholder Name:		Relationship to patient:
Policyholder DOB:	Policyholder SSN:	Policyholder Employer:

EMPLOYMENT INFORMATION

Patient's Employer:	Employer's Phone Number:
Insured's Employer:	Insured's Employer's Phone

IF PATIENT IS A MINOR, PLEASE LIST BOTH PARENTS NAME AND EMPLOYERS

Mother:	Employer:	Employer's Phone number:
Father:	Employer:	Employer's Phone number:

NEXT OF KIN INFORMATION

Name of nearest relative (or friend, not spouse), not living with you:	Phone:	Relationship:

WHO REFERRED YOU TO OUR OFFICE?

☐Adjustor ☐Attorney ☐Billboard ☐Case Manager ☐Doctor ☐Employer ☐Friend ☐Hospital ☐Insurance
☐Magazine ☐Neighbor ☐Phone Book ☐Physical Therapist ☐Coach ☐Radio ☐School ☐Trainer ☐Other

THIRD PARTY BILLING

Is your injury work related? ☐Y ☐N	Is Your Injury due to an accident? ☐Y ☐N	If your injury is MVA related, have You obtained an accident report? ☐Y ☐N

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG/HPI Privacy Notice

SIGNATURE:	DATE:

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HPI PHYSICIANS, LLC

Authorization to release information via Phone/Family/Friends

Patient Name:____DOB:_______________

I hereby authorize confidential communications from the physicians or staff of OSSO and/or HPI Physicians regarding my health, care, treatments, appointments, prescriptions, etc.. to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail 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

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AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopedics (OSSO) or HPI Physicians (HPI-P) to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of OSSO or HPI-P to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of OSSO or HPI-P charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to , insurance companies, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCHA S HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW 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 & Orthopedics, its agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at OSSO or HPI-P. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release OSSO or HPI-P from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

Signed____ Date ______________________________
(Patient)

OR____ __________________________________
(Nearest relative or 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 confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

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A DIVISION OF THE PHYSICIANS' GROUP or HPI PHYSICAN, LLC

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopedics (OSSO) are your healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care. We specialize in adult and pediatric orthopedics, sports medicine, physical medicine and rehabilitation, pain management, reconstructive and orthopedic spine and hand surgery.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card, or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.486.6800 to make financial arrangements. Please be aware that charges or 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 of a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. **Please note that not all OSSO/HPI-P Physicians will accept third party/MVA patients.**

There is a $35 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion. There is a $50 charge for any appointments not cancelled within 24 hours.

If you require surgery or other invasive procedures are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Dr. Daron Hitt to participate in your care.

Sincerely,
Physician and Staff

My signature below acknowledges receipt of this financial policy:

Signed ____**Date**__________________

Relationship if other than patient ____

********THIS MUST BE SIGNED IN ORDER FOR US TO BILL ON YOUR BEHALF**

DARON C. HITT, M.D.

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POST SURGERY OPIOID CONSENT FORM

Instructions: Please review the information listed below and **initial next to each item** when you have reviewed and feel you understand and accept what each statement says.

Patient Name:	**DOB:**
	Initials
My surgeon will prescribe an opioid medication to help my control and manage post-surgical pain.	
This medicine is 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 medication 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 the 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:	

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ________________________________ Medical Record #: ___________________________

Date of Birth: _________________________________ Social Security #: _____________________________

I hereby authorize ____
Name of person / organization disclosing PHI

To release the following information to **DARON C. HITT M.D.**
Name and Address of Person/ Organization Receiving PHI
3115 SW 89th Street OKC, OK 73159 P: 405.486.6800 F: 405.426.6441

___

Information to be shared:

- ☐ Psychotherapy Notes (if checking this box: no other boxes may be checked.
- ☐ Entire Medical Record
- ☐ Billing information for ____
- ☐ Mental Health Record
- ☐ Substance Abuse Records
- ☐ Medical information compiled between ___________ and ___________
- ☐ Other: ____

The information may be disclosed for the following purpose(s) only:

- ☐ Insurance
- ☐ Continued Treatment
- ☐ Legal
- ☐ At my or my representative's request
- ☐ Other: ____

I understand that by voluntarily signing this authorization:

- I authorized the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS, and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: __________________________
____

____ __________________________
Signature of Patient or Legal Representative Date

____ _________________________________
Description of Legal Representative's Authority Expiration date (if longer than 1 year from date of signature or no event is indicated)

APPOINTMENT NO SHOW AND LATE POLICY

Appointment No Shows

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than the Friday prior to your appointment.

- The first NO SHOW will result in a call or e-mail reminding you that you have missed your appointment and will need to reschedule for another day.
- The second NO SHOW will result in a call or e-mail and a $50.00 **charge to the patient, not** your insurance company. This must be paid prior to scheduling your next appointment.
- The third NO SHOW will result in a dismissal from the practice.
- NO SHOW **can** result in dismissal from practice immediately.

Late Policy

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day. If you are late to your appointment, but do not call us prior to your appointment time, we will give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Post-Operative patients arriving 10-30 minutes late will be seen, but will have to wait while we see patients who arrived to their scheduled appointment on time.
- Non Post-operative patients arriving 10-30 minutes late will be asked to reschedule.
- Any patient arriving more than 30 minutes late will be asked to reschedule.

____ ____

Signature of Patient | Signature of Parent or Guardian (if applicable)

____ ____

Print Name of Patient | Print Name of Parent or Guardian

____

Date

Daron Hitt M.D.
3115 S.W. 89th Street
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
☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R

PAIN/COMPLAINTS

Pain level______/ 10 (example; 0/10 = NO PAIN; 10/10 = SERVERE PAIN)

☐ sharp ☐ stabbing ☐ aching ☐ throbbing ☐ burning ☐ shooting

☐ numbness ☐ tingling ☐ Other____

ALLERGIES: ☐ **No Known Allergies**

☐ Medications ____

☐ Shellfish ☐ Contrast Dye ☐ Latex ☐ Genera/Local ☐ Anesthesia

PHARMACY:

NAME: _____________________________________PHONE NUMBER: __________________________

ADDRESS: ____

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: (can use back of sheet, if needed) ☐ NO past surgeries

Operation Surgeon Year

____

____

____

____

____

____

____

Name:____ DOB:________________ Today's Date:______________

FAMILY HISTORY: ☐ **Family History Unknown**

Arthritis ☐ Y ☐ N Whom: ____
Diabetes ☐ Y ☐ N Whom: ____
Heart disease ☐ Y ☐ N Whom: ____
Stroke ☐ Y ☐ N Whom: ____
Hypertension ☐ Y ☐ N Whom: ____
Cancer ☐ Y ☐ N Whom: ____

SOCIAL/PERSONAL HISTORY:

Do you smoke tobacco products? ☐ Y ☐ N If yes,______ packs per day for ____ years?

Are you 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

** *FEMALES*** Any chance you may be pregnant. ☐ Yes ☐ No ☐ Maybe

REVIEW OF SYSTEMS: Please check any of the following that you have experienced within the last 3 months or are experiencing now in general, does not have to related to reason for visit.

☐ 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	☐ Pigment change
☐ Anemia	☐ Easy bruising	☐ 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	☐ Nose bleeds	☐ Bleeding gums	☐ Ear ache	
☐ Difficulty swallow	☐ Depression	☐ Sleep Difficulties	☐ NONE OF THE ABOVE	