

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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated										
Patient's Address:					Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Full Time Student <input type="checkbox"/> Part Time Student <input type="checkbox"/> Retired									
City:			State:		Zip Code:		Referring Physician:				Primary Care Physician:			
Home Phone:		Work Phone:			Cell Phone:				Email:		<input type="checkbox"/> Patient Declined			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline				Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Pacific <input type="checkbox"/> Multiple <input type="checkbox"/> Other						Preferred Language:				

INSURANCE INFORMATION – We Will Need a copy of your insurance card in order to file a claim

WORKERS COMPENSATION

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:	
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WHO REFERRED YOU TO OUR OFFICE?

<input type="checkbox"/> Adjustor	<input type="checkbox"/> Attorney	<input type="checkbox"/> Billboard	<input type="checkbox"/> Case Manager	<input type="checkbox"/> Doctor	<input type="checkbox"/> Employer	<input type="checkbox"/> Friend	<input type="checkbox"/> Hospital	<input type="checkbox"/> Insurance
<input type="checkbox"/> Magazine	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Coach	<input type="checkbox"/> Radio	<input type="checkbox"/> School	<input type="checkbox"/> Trainer	<input type="checkbox"/> Other

THIRD PARTY BILLING

Is your injury work related? <input type="checkbox"/> Y <input type="checkbox"/> N		Is Your Injury due to an accident? <input type="checkbox"/> Y <input type="checkbox"/> N		If your injury is MVA related, have You obtained an accident report? <input type="checkbox"/> Y <input type="checkbox"/> N	
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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 SUCH AS 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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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.)
- Billing information for _____
- Substance Abuse Records
- Other: _____
- Entire Medical Record
- Mental Health Record
- Medical information compiled between _____ and _____

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:

Please check any studies, include date:

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

- 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 (example; 0/10 = NO PAIN; 10/10 = SEVERE 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 | <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: (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.

- | | | | | |
|---|--|--|--|---|
| <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"/> Pigment change |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> 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"/> Nose bleeds | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Ear ache | |
| <input type="checkbox"/> Difficulty swallow | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> NONE OF THE ABOVE | |

Work activities performed on present occupation **(after injury, 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

___ 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?

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