OSSO
HEALTHCARE NETWORK
EDMOND
1616 S. Kelly • Edmond, Oklahoma 73013 • (405) 330-0032 • FAX (405) 715-8808

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	SPOUSES NAME:	RACE:

PATIENT'S ADDRESS:			REFERRING PHYSICIAN:	ETHNICITY:
CITY:	STATE:	ZIP CODE:	Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired	PREFERRED LANGUAGE:
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

Patient's Employer _____ Ph# _____

Insured Employer _____ Ph# _____

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

Mother _____ Employer _____ Ph# _____

Father _____ Employer _____ Ph# _____

NEXT-OF-KIN INFORMATION

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

HOME PHONE: ( )	RELATIONSHIP TO THE PATIENT:

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 Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature _____ Date _____

- The pain you are experiencing may be improved, but not eliminated, with the use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be phoned in should you be unable to keep these appointments.
- This office fills pain medications for surgical patients only. They are not filled indefinitely. After a period of time your doctor will taper your medications for discontinuation. If discontinuation is not possible or you are not a surgical candidate you will be referred for long-term pain management.
- Your treating physician is to be the only physician who prescribes narcotic pain medications to you.
- It is your responsibility to notify us of any other physician who is prescribing narcotic pain medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing you narcotic pain medications.
- Individuals must be aware that " doctor shopping " is viewed as narcotic drug seeking behavior and is not tolerated. Should this type of behavior occur, your narcotic pain medications will not be refilled and you will be dismissed as a patient.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- Pain medication refill requests are taken and called in MONDAY thru FRIDAY from 8:30 am to 3:30 pm ONLY. PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS, OR AFTER HOURS FOR ANY REASON. We guarantee prescription refills will be processed within 48 hours of the request.
- Federal and state law carefully regulates dispensed or written prescriptions for narcotic medications. Forging or altering a narcotic prescription, or distributing medications to others of their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and be reported to the DEA, Police and FDA.
- Lost, stolen, or misplaced prescriptions or medications ARE NEVER REPLACED- NO EXEPTIONS. Your medications and prescriptions are your responsibility.
- Narcotic pain medications may cause sedation and dizziness. You should not drive an automobile nor operate any machinery when taking medications.

Informed consent: I,_____, have been informed and clearly understand the above listed issues regarding the treatment of pain with narcotic pain medications. I understand that this agreement will be filed in my chart as a part of my permanent medical record.

Signature_____ 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.

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.

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 unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover Card, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 427-6776 to make payment arrangements. 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.

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 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 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 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: _____

Chart No. _____

Oklahoma Sports Science and Orthopaedics

Authorization to Release Information via phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of OSSO 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 plan, 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 this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature Date

OSSO STAFF ONLY:

Documented by:

_____ _____

Initials Date

The Physicians' Group, LLC
HPI Physicians, LLC

HP Form 01

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how The Physicians' Group, LLC or HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient's Name (print):_____

Patient's Date of Birth: _____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:_____

_____

_____ Date:_____

Signature of Patient or Patient's Personal Representative

Current Contact Information for Patient or Personal Representative signing this form:

Name (print): _____

Address:_____

Telephone Number: _____

Email: _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgment but did not because:

_____ It was emergency treatment.
_____ I could not communicate with the patient.
_____ The patient refused to sign.
_____ The patient was unable to sign because_____.
_____ Other:_____.

_____ _____

Signature Practice Staff Member Date

Name: _____
Title: _____

This form should be placed in the patient's medical record.

OKLAHOMA SPORTS SCIENCE AND ORTHOPEDICS- PAIN MANAGEMENT

Name:	Birthdate:	Date:

MAIN PROBLEM:_____

How long has this problem been present? _____Days _____Weeks _____Months _____Years

How did your problem begin?

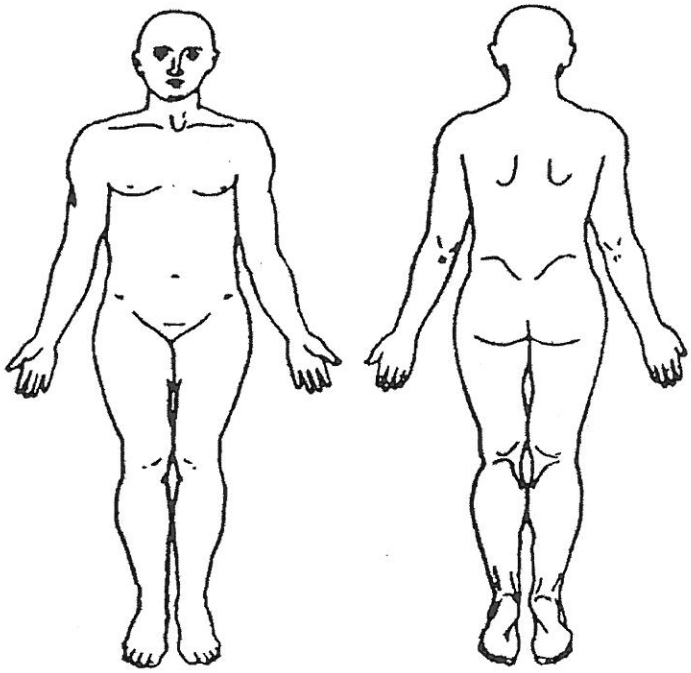
_____

_____

Please place "XX" on diagram for where you feel pain.

Please place "OO" on diagram where you feel numbness/tingling.

Right **Left** **Left** **Right**



Any additional qualities of your pain?

Have you lost control of your bladder or bowel?

Describe Your Pain (Place an X by the word)

_____**Thobbing** _____**Gnawing**

_____**Shooting** _____**Heavy**

_____**Stabbing** _____**Tender**

_____**Sharp** _____**Splitting**

_____**Cramping** _____**Sickening**

_____**Burning** _____**Aching**

_____**Other (Describe)**

What positions or activities make the pain worse? ----------

What positions or activities make the pain better?

_____

_____

_____

Put a circle around the number that best describes your pain over the past week. A square around the highest number and a triangle around the lowest number.

0 1 2 3 4 5 6 7 8 9 10

PREVIOUS TREATMENT OF INJURY (Please circle yes or no; and circle the corresponding description):

Yes No Primary Care Physician (Family Practioner)

Yes No Medical Specialist (Neurosurgeon, Orthopedist, Pain Physician, Neurologist)

Yes No Physical Therapy/Chiropractor/Acupuncturist

Yes No Back Exercises/Yoga/Pilates/Back Class

Yes No Back Shots (Epidural Steroid Injections/Facet Blocks/Discogram/Rhizotomy/other)

Yes No MRI/CT scan/Myelogram/Bone Scan/EMG

OCCUPATIONAL HISTORY:

Is today's problem related to an on-the-job injury? **YES** **NO** (If yes, please complete the entire section, if no please skip and move to next section, medications).

DATE OF INJURY_____

CURRENT WORK STATUS (Circle one): Full duty Restricted duty TTD Disabled

Have you filed a claim with your employer? **YES** **NO**

Do you have or anticipate litigation (lawsuit) regarding today's problem? **YES** **NO**

MEDICATIONS: Please list all medications that you are taking, including vitamins and supplements:

NAME OF MEDICATION	DOSAGE (Strength of the pill)	NUMBER OF PILLS EACH DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES:_____

REACTION:_____

PAST MEDICAL HISTORY: (Please fill in the circle if you have any of the following illnesses; please explain)

- ○ NONE
- ○ DIABETES (Circle: type I / type II):_____
- ○ HEART PROBLEMS:_____
- ○ RESPIRATORY PROBLEMS:_____
- ○ BLEEDING DISORDER:_____
- ○ OSTEOPOROSIS:_____
- ○ STOMACH/GI PROBLEMS:_____
- ○ KIDNEY OR LIVER DISEASE:_____
- ○ NEUROLOGICAL DISEASE:_____
- ○ CANCER:_____
- ○ THYROID DISEASE:_____
- ○ OTHER MEDICAL DIAGNOSIS: _____

_____

_____

FAMILY HISTORY (Please check with an "X")	**FATHER**	**MOTHER**	**SIBLING**	**GRANDPARENT**	**OTHER**
CANCER					
MENTAL ILLNESS					
HEART DISEASE/HYPERTENSION					
DIABETES/THYROID/ENDOCRINE					
LIVER/KIDNEY DISEASE					
PULMONARY DISEASE					
MUSCLE DISEASE					
NEUROLOGIC/STROKE					
HEMATOLOGIC/BLEEDING					

OTHER (PLEASE LIST): _____

PAST SURGICAL HISTORY:

Type of Surgery	Date	Complications

SOCIAL HISTORY:

Single Married Divorced Separated Widowed

Children or dependents at home (numbers, ages):_____

Occupation:_____

HABITS:

Do you smoke: **YES** **NO** _____Packs per day _____Years

Do you use tobacco products: **YES** **NO**

Do you drink alcohol: **YES** **NO**

Please answer the following questions regarding alcohol:

1. Have you ever felt you needed to cut down on your drinking? **YES** **NO**
2. Have people annoyed you by criticizing your drinking? **YES** **NO**
3. Have you ever felt guilty about drinking? **YES** **NO**
4. Have you ever felt you needed a drink first thing in the morning to Steady your nerves or to get rid of a hangover? **YES** **NO**

Do you currently use any recreational drugs or have a history of use? **YES** **NO**

If yes, please explain:_____

Have you ever been addicted to recreational drugs, prescription medications from other doctors or have ever undergone treatment for addiction at a rehabilitation center or equivalent? **YES** **NO**

If yes, please explain:_____

Have you ever been released from care or fired from another doctor? **YES** **NO**

If yes, please explain:_____

How many caffeinated drinks (coffee, tea, soda, energy drinks, etc) do you drink per day? _____

What recreational activities do you participate in? (circle those that apply)

WALKING **WEIGHT TRAINING** **SWIMMING** **JOGGING**

EXERCISE MACHINES **CYCLING** **YOGA/PILATES** **MARTIAL ARTS**

OTHER (PLEASE LIST): _____

SLEEP HISTORY:

Please rate the following from 0-3 with:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

1. Sitting and reading _____
2. Watching TV _____
3. Sitting inactive in a public place (e.g. a theater or a meeting) _____
4. As a passenger in a car for an hour without a break _____
5. Lying down to rest in the afternoon when circumstances permit _____
6. Sitting and talking to someone _____
7. Sitting quietly after a lunch without alcohol _____
8. In a car, while stopped for a few minutes in traffic _____

ADDITIONAL QUESTIONS:

1. Do you snore loudly (louder than talking or can be heard through closed doors? **YES NO**
2. Do you often feel tired, fatigues, or sleepy during daytime? **YES NO**
3. Has anyone observe you stop breathing during your sleep? **YES NO**
4. Are you now or have you ever been treated for high blood pressure? **YES NO**

REVIEW OF SYSTEMS (Please circle if applicable):

Constitutional
Fevers
Chills
Night Sweats
Unexplained Weight Loss

Cardiac
Chest Pain
Heart Palpitations
Irregular heart beat

Skin
Rash
Skin Breakdown

Endocrine
Thyroid issues

Neurological
Headaches
Vision Problems
Hearing Problems
Dizziness

Psychiatric
Depression
Anxiety
Thoughts of hurting yourself or another

Genitourinary
Urinary Problems
Sexual Difficulties

Gastrointestinal
Difficulty Swallowing
Stomach Pain
Nausea
Vomiting
Constipation or Diarrhea

Musculoskeletal
Swollen Joints
Chronic Fatigue
Swollen Arms or Legs

Pulmonary
Shortness of breath
Cough

HEALTH QUESTIONS:

Over the past 2 weeks, how often have you been bothered by any of the following problems (fill in the circle)?

	Not at all	Several Days	More than Half the Days	Nearly Every Day
• Little interest or pleasure In doing things	○	○	○	○
• Feeling down, depressed or hopeless	○	○	○	○
• Trouble falling or staying asleep, or sleeping too much	○	○	○	○
• Feeling tired or having little energy	○	○	○	○
• Poor appetite or overeating	○	○	○	○
• Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
• Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
• Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
• Thoughts that you would be better off dead, or of hurting yourself	○	○	○	○

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4
11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Donald Adams has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____
Signature of Patient

_____
Signature of Parent or Guardian
(if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian

Dated:_____