OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.
OSSO SPINE AND PAIN MANAGEMENT CENTER
3110 SW 89TH, SUITE 102C, OKLAHOMA CITY, OKLAHOMA 73159

Dr. Jason Leinen, M.D., ATC Ph: (405) 703-3611 Fx (405) 703-3711

NEW PATIENT INFORMATION (PLEASE PRINT AND FILL IN ALL BLANKS)

PATIENT'S LEGAL LAST NAME: FIRST NAME MIDDLE INITIAL	SEX	BIRTH DATE	AGE

SOCIAL SECURITY NO:	MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐SEPERATED
PATIENT'S ADDRESS:	ARE YOU: ☐EMPLOYED ☐STUDENT ☐RETIRED ☐NOT EMPLOYED

CITY:	STATE:	ZIP CODE:	REFERRING PHYSICIAN:

HOME PHONE:	CELL PHONE:	

INSURANCE INFORMATION: WE WILL NEED A COPY OF YOUR CARD TO FILE A CLAIM

NAME OF INSURAND POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

NAME OF INSURANCE COMPANY:_____POLICY #:_____

GROUP #:_____CARRIERS SSN: _____EMPLOYER:_____

CARRIERS EMPLOYER:_____

SECONDARY INSURANCE (IF APPLICABLE) POLICY HOLDER: _____RELATIONSHIP TO PATIENT:_____

NAME OF INSURANCE COMPANY:_____POLICY #:_____

GROUP #:_____CARRIERS SSN: _____EMPLOYER:_____

EMPLOYMENT INFORMATION

☐ N/A PATIENT EMPLOYER:_____PHONE:_____
☐ N/A INSURED EMPLOYER:_____PHONE:_____

IF THE PATIENT IS A MINOR, PLEASE LIST BOTH PARENTS NAMES AND EMPLOYER INFORMATION
☐ N/A MOTHER: _____EMPLOYER:_____PHONE:_____
☐ N/A FATHER:_____ EMPLOYER:_____PHONE:_____

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (or friend, not spouse) NOT LIVING WITH YOU:

PHONE:	RELATIONSHIP TO PATIENT:

THIRD PARTY BILLING

IS YOUR INJURY WORK RELATED? ☐YES ☐NO IS THIS INJURY ACCIDENT RELATED? ☐YES ☐NO

IF THIS INJURY IS DUE TO A MOTOR VEHICLE ACCIDENT, HAVE YOU OBTAINED AN ACCIDENT REPORT? ☐YES ☐NO

I hereby authorize my insurance benefits to be paid directly to the facility and the physician and 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 TPG notice of privacy practices.

Signature Date

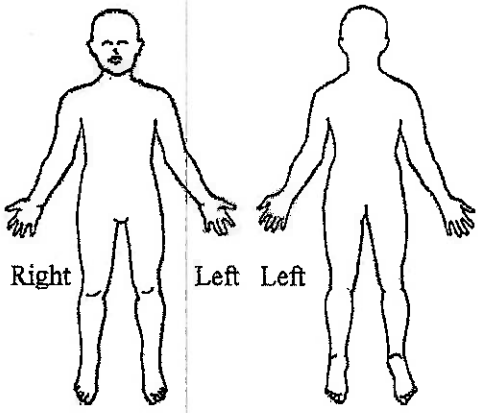
Patient Name: _____ DOB: _____ Entered by: _____Audited: _____

Today's date: _____

Medical History Form

Reason for Visit

Please shade your areas of pain below:



Reason for being seen today? _____
Onset of Pain? _____

Do you experience any Numbness or Tingling? (Check all that apply)
☐Arms ☐Hands ☐Fingers ☐Hips ☐Legs ☐Feet ☐Toes ☐Other _____

Do you experience any Weakness? ☐Yes ☐No Where?_____
Right

Does anything make the pain BETTER? (Check all that apply)
☐Sitting ☐Standing ☐Walking ☐Bending forward/backward
☐Coughing/Sneezing ☐Medication ☐Exercise

Does anything make the pain WORSE? (Check all that apply)
☐Sitting ☐Standing ☐Walking ☐Bending forward/backward
☐Coughing/Sneezing ☐Medication ☐Exercise

Describe the pain (Check all that apply)
☐Sharp ☐Tender ☐Burning ☐Aching ☐Gnawing ☐Stabbing ☐Shooting ☐Continuous ☐Intermittent

Please rate your pain: 0 (No Pain) 1 2 3 4 5 (Moderate) 6 7 8 9 10 (Worst Possible Pain)

Are your current medications helpful? ☐Yes ☐No

Which physician prescribed it last?

Have you ever participated in Physical Therapy for this condition? ☐Yes ☐No When? _____

Was Physical Therapy helpful? ☐Yes ☐No

Who referred you? _____

Date of Injury: _____ Date Symptoms Began: _____

Is this Condition Related to: ☐Work ☐Motor Vehicle Accident ☐Sports Injury ☐Other: _____

If Yes, How did the injury happen? _____

Where? _____ What time?_____

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

Review of Systems

Are you experiencing any of the following symptoms?

General:
☐ Chills
☐ Excessive Weight Gain/Loss
☐ Fever
☐ Night Sweats

Skin:
☐ Rash

HEENT:
☐ Hearing Problems
☐ Visual Problems

Respiratory:
☐ Cough
☐ Shortness of Breath

Cardiovascular:
☐ Chest Pain

Gastrointestinal:
☐ Constipation
☐ Diarrhea
☐ Difficulty Swallowing
☐ Nausea
☐ Stomach Pain
☐ Vomiting

Genitourinary:
☐ Sexual Difficulty
☐ Urinary Problems

Musculoskeletal:
☐ Joint Swelling
☐ Swollen arms/legs

Neurologic:
☐ Dizziness
☐ Headaches

Psychiatric:
☐ Alcoholism
☐ Depression
☐ Substance Abuse

Hematology:
☐ Swollen Lymphadenopathy

Past Medical History

☐ Asthma
☐ Abnormal EKG
☐ Arthritis
☐ Back Trouble
☐ Bleeding Disorder
☐ Blood Disease (Anemia, etc)
☐ Cancer
☐ Diabetes
☐ Emphysema/other lung problems
☐ Epilepsy or Seizures
☐ Facial Bone Fractures
☐ Glaucoma
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Mono
☐ Muscle Weakness
☐ Neck Trouble
☐ Paralysis
☐ Positive HIV/AIDS test
☐ Stroke
☐ Thyroid Disease
☐ Ulcers
Other: _____
_____
_____

Social History

Tobacco: ☐ Never
☐ Current: Cigarettes ☐Yes ☐No Amt:_____pck/day Has been smoking for? _____
Smokeless Tobacco ☐Yes ☐No Amt:_____per day
Cigars ☐Yes ☐No Amt:_____# week
☐ Quit: Year last smoked _____ Amt: _____pck/day How many years did you smoke?_____

Alcohol use: ☐Yes ☐No _____# drinks per day / week / occasional / social

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Occupation: _____
Children or Dependents at Home: _____

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

Family History

Have any of your family members had any of the following problems?

☐ Arthritis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Kidney Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Liver Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Lung Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Muscle Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Neurological Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other:_____	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other:_____	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other:_____	☐ Father	☐ Mother	☐ Sibling	☐ Other_____

List all **ALLERGIES** to any medications **and** the reactions: ☐ No Known Drug Allergies

Medication	Reaction

CURRENT MEDICATIONS: (Please include over the counter medication and food supplements.)

Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____
Drug Name: _____ Dose: _____ How Often: _____

☐ None

Pregnancy

Could you be pregnant? ☐Yes ☐No

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

Past Surgical History

List all of the SURGERIES you have had:

Type of Surgery	Year	Type of Surgery	Year

Have you had any orthopedic complaints resulting in radiology procedures in the last year? (ex: X-ray, MRI, CT scan)

Radiology Procedure	Year	Radiology Procedure	Year

What is your preferred pharmacy (Please include name and phone number and/or location):_____

_____

What is your preferred mail order pharmacy (Please include name and phone number): _____

_____

Are you presently involved in a lawsuit? ☐Yes ☐No If yes, body part involved: _____

Have you been treated before for this injury? ☐Yes ☐No

Where x-rays or tests done? ☐Yes ☐No

Did you bring them or a report with you? ☐Yes ☐No

Are you able to continue activity or work? ☐Yes ☐No

Location of Pain: _____

Diagnosis given: _____ Treatment given: _____

Was surgery performed? ☐Yes ☐No
If so, please obtain operative report or notify the receptionist so she may obtain a copy for our records.

Date of Surgery: _____ Surgery Performed: _____

Patient Signature: _____
Date: _____

Chart No.

Oklahoma Sports Science and Orthopedics

Authorization to Release Information via Family and Friends

Patient Name: _____

DOB: _____

I hereby 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: _____

Relationship: _____

Name: _____

Relationship: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____

Patient Signature Date

Dr. Leinen's Office Reminders

We ask that all patients go over the following friendly reminders for the clinic:

- Please call in refill requests seven (7) days prior to your prescription running out in order to ensure our office is able to appropriately schedule and send out these requests (**If you are seen in clinic each month, then you do not require a seven day call ahead; this is pertinent to months that you do not have an in-person visit**).

  Initial: _____

- Phone encounter refills are called in on Monday through Thursday at the end of clinic.

  Initial: _____

- Only one (1) pharmacy will be used. Prescriptions will not be called into multiple pharmacies (with the exception of a pharmacy's inability to fill the sent prescription).

  Initial: _____

- No refill requests will be taken on **Friday,** unless you have a scheduled in-office appointment.

  Initial: _____

- Only one (1) message is required for refill requests. Multiple calls may delay the process.

  Initial: _____

- Pain medication will be at your pharmacy at the **end** of the clinic day, even if you attend an appointment in office. If it is not a narcotic, prescriptions will be called in shortly following each visit.

  Initial: _____

- **NO** medication will be filled **early**.

  Initial: _____

- If you are seen for Pain Management, please be prepared to do a UDS (drug screen). A screen is required each visit with commercial insurance or self-pay.

  Initial: _____

- All **self-pays, co-pays and balances** are due at the time of service. No Exceptions.

  Initial: _____

- **Our new office hours will be: Monday – Thursday 8:00 am to 5:00 pm, and Fridays 8:00 am to 12:00 pm.**

For any questions, a staff member will gladly discuss these reminders with you. Thank you.

_____ _____

Name/Signature Date

OSSO Spine and Pain Management
Jason Leinen, M.D., ATC

PATIENT-PROVIDER AGREEMENT AND INFORMED CONSENT: CHRONIC PAIN

Print Patient Name: _____DOB: _____

The purpose of this Agreement is to give the patient information about certain medications the patient will be taking for chronic pain management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines, and stimulants may cause addiction and is only one part of a complete treatment plans.

I agree to the following:

1. I am being prescribed _____, an opioid pain medication, as part of my treatment plan to manage my chronic pain. The pain I am experiencing may be improved, but not eliminated, with the use of these opioid medications. My treatment plan also includes the following alternatives: _____.
2. Opioids are a type of powerful pain medication often called narcotics. They can be very useful in managing pain, but they have a high potential for dependency and addiction.
3. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will store opioid medications in a secure location to prevent others from taking them and will safely dispose of them when I am no longer using them.
4. I will not take any medicine not prescribed to me.
5. Forging or altering a prescription or distributing medications to others is a crime. I understand that should any of the above occur, my care with this office will be terminated and I will be reported to law enforcement authorities.
6. Excessive phone calls requesting increased dosage or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
7. I will not increase my medicine until I speak with my doctor or nurse.
8. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
9. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
10. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
11. I will agree to come to the office for a pill count at any time if asked by my doctor.
12. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
13. I will inform my doctor about all other medicines I am taking. Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system depressants is highly dangerous and can be fatal.
14. I agree to give blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit and again randomly throughout the course of my treatment.

15. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics and Dangerous Drugs Prescription Monitoring Program.
16. There are several risks of opioid medications that my treating physician has discussed with me. Some of those risks include sleepiness or drowsiness, impaired mental or motor ability, slowing of breathing rate, skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, swelling, physical or psychological dependence, tolerance to analgesia (meaning you require more medicine to get the same pain relief), and addiction. Opioid medications are highly addictive even when taken as prescribed. Overdose of opioid pain medication can lead to breathing difficulty and even death. Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system depressants is highly dangerous and can be fatal. It is my responsibility to inform my treating physician about all other medicines I am taking opioid medications.
17. I should not drive an automobile or operate any machinery when taking opioid medications.
18. I understand that opioid medications can adversely affect my judgement in making business decisions.
19. My treating physician has discussed with my alternative pain management approaches that may be available to manage my pain instead of taking opioid pain medications and the risks and benefits of the alternatives.
20. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control, and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
21. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence that I am improving, or that progress is being made to improve my function and quality of life, my medication regime will be tapered, and my care will be referred back to my primary care physician.
22. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medication.

Refills

- I understand that refills of opioid medication will be given only during my regularly scheduled appointment or once monthly by telephone if the current prescription has been correctly used. If the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.
- I understand that refills will be made only during regular office hours—MONDAY through THURSDAY, 8:00AM-5:00PM and Friday 8:00 AM to 12:00 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 3 business days is required.
- I must keep track of my medications. No early or emergency refills may be made. Lost, stolen, or misplaced prescription medications ARE NEVER REPLACED-NO EXCEPTIONS.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is _____.

Emergencies
In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain opioids from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if opioids have been obtained from another physician.

Prescription from Other Doctors
If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the emergency room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination of Agreement
If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors, or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

No-call, No-shows
A no-call, No-show for a scheduled appointment/procedure will result in a fee. Multiple no shows could result in a termination from this practice.

IINFORMED CONSENT

I, _____, have been informed and clearly understand the above listed issues regarding the treatment of pain with opioid pain medications. I have talked about this agreement with my doctor, and I understand the above rules. I understand that this agreement will be filed in my chart as part of my permanent medical record.

Signature of Patient: _____ Date: _____

Signature of Physician: _____

If the patient is a minor, the patient's parent or guardian must consent by signing below.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Gaurdian: _____

Oklahoma Spine and Pain Management

Financial Policy

Thank you for choosing Oklahoma Spine and Pain Management as your healthcare provider. At OSPM we are dedicated to providing the highest quality, most cost effective care, specializing in adult and pediatric orthopedics, sports medicine, running injuries, physical medicine and rehabilitation, pain management.

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 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 and YOU may be responsible for any procedures/services rendered. It is important that you are aware of your insurance policy provisions and coverage.

Accurate up to date information is the patient's responsibility; please notify our office of any changes in you insurance or personal billing information. Please bring to each appointment, your 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 are due at the time of service. Payments can be made by cash, check, and money order, Visa, Discover or MasterCard. If you have a financial concern regarding your balance, please contact the office/billing manager at 405-703-4950. 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. Not all of our physicians accept self-pay accounts. Payments on self-pay accounts is due at the time of service.

If your injury was due to a Motor Vehicle Accident, 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 payments to the Physician.

There will be 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, Northwest Surgical Hospital, Community Hospital or Bone and Joint 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 Spine and Pain Management to participate in your care.

Sincerely,

OSPM Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed_____ Date_____

Relationship if other than patient _____

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient 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 physicians 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 COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILLIS, GONORRHEA OR THE HUMAN IMMUNODEFIENCY 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 or my property, including money and jewelry.

I understand a photocopy of this document is a valid as the original.

SIGNED_____ DATE_____
(PATIENT)

OR _____ WITNESS TO SIGNATURE _____
(NEAREST RELATIVE
RESPONSILBE PARTY)

_____ POLICY HOLDERS SIGNATURE _____
(RELATIONSHIP TO PATIENT)

NOTICE TO PATIENTS: Information in your medical record that you have/may have communicable or venereal disease is made it confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have has risk exposures, release pursuant to an order of this 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.

OSPM Physicians
3110 SW 89th Street Ste 102 C
Oklahoma City, OK 73159
AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM ANOTHER PROVIDER

Patient Name: _____ DOB: _____

Social Security: _____ Telephone: _____

I am the _____ Patient, _____ Guardian, _____ Parent of Minor Child, _____ Personal Representative and hereby authorize _____ personnel to disclose medical information on the above named patient to:

Dr. Jason M. Leinen, M.D., ATC
3110 SW 89th Street Ste 102 C
Oklahoma City, OK 73159
Phone (405) 703-3611
Fax (405) 703-3711

Purpose of disclosure:_____

Date(s) of admission/treatment: _____
Information requested:

_____ Face Sheet _____ Dictated reports _____ Pathology reports _____ EKG reports

_____ Progress notes _____ Radiology films _____ Radiology report(s) ____ Lab report(s)

_____ Complete medical record(s) _____ other _____

I understand that this authorization will automatically expire one year from the date of my signature. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. Also, I understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on authorization. To cancel this authorization, send a written request to HPI Physicians, 3110 SW 89th street, ste 102 Oklahoma City, OK 73159.

Information in your medical record that you have or may have communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances, including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers involved in care or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless the identifying information is released to you, by an order of the court or the Department of Health or by law.

I UNDERSTAND THAT THE INFORMATION AUTHORIZED FOR RELEASE MAY CONTAIN INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Information release may include alcohol and drug abuse records protected under the Code of Federal Regulations and psychiatric records. Re-disclosure of alcohol and drug abuse records by the recipient is prohibited without specific authorization. If the records are psychiatric in nature the attending physician must consent to release of medical records.

_____ _____
Date Signature of Patient/Personal Representative

If Personal Representative, describe your authority to sign for the patient: _____

_____ _____
Signature of Witness Relationship to Patient

Your health information that you have authorized to disclose may be subject to disclosure by the recipient and no longer subject to protection under the federal privacy regulations.

Welcome to Electronic Communications from Our Office

OSSO Spine and Pain Management (OSPM) is pleased to offer its patients the opportunity for electronic communications about medical records, appointments, new services, health trends and tips.

This includes access to Follow My Health Patient Portal, as a secure online means for you to access your confidential medical record information, anytime and anywhere.

With the portal tool you can:

- Review your medical records
- Request an appointment
- Request prescription refills
- See your lab results

Please provide your e-mail address so you can get started today.

_____ I accept

_____ I decline

My email address is: _____

First & Last Name: _____

Date of Birth: _____

Please Print