# OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

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www.ossonetwork.com

## 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

PATIENT'S ADDRESS:

Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired

| CITY: | STATE: | ZIP CODE: | REFERRING PHYSICIAN: |
|---|---|---|---|
| | | | |

| 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

N/A ❑ Patients Employer _____ Ph# _____

N/A ❑ Insured Employer _____ Ph# _____

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

Mother _____ Employer _____ Ph# _____

N/A ❑ Father _____ Employer _____ Ph# _____

## NEXT-OF-KIN INFORMATION

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

| HOME PHONE: | RELATIONSHIP TO THE PATIENT: |
|---|---|
| ( ) | |

## WHO REFERRED YOU TO OUR OFFICE?

❑ Adjustor ❑ Attorney ❑ Billboard ❑ Case Manager ❑ Coach ❑ Doctor ❑ Employer ❑ Family ❑ Friend ❑ Hospital
❑ Insurance Co. ❑ Magazine ❑ Neighbor ❑ Newspaper ❑ Phone Book ❑ Physical Therapist ❑ Radio ❑ School ❑ Trainer

## 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 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 Privacy Notice.**

Signature Date

## Oklahoma Sports Science and Orthopedics
## MEDICAL HISTORY QUESTIONNAIRE

(To ensure the most accurate records possible, we ask that this form be updated on an annual basis.)

Patient Name _____ Social Security Number _____
Gender (circle): Male Female Age _____ Date of birth _____
Height: _____ Weight: _____ Pharmacy _____ _____ # _____
Street _____ State _____

**Reason for Visit:** _____
**Is this a Workman's Compensation visit?** _____
**Date of injury:** _____
**What part of body was injured?** _____
**Describe injury:** _____

**PAST MEDICAL HISTORY**

Do you currently or have you ever had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| **Diabetes** | **Yes / No** | **High Blood Pressure** | **Yes / No** | **Staph Infection (MRSA)** | **Yes / No** |
| **Heart Disease** | **Yes / No** | **Seizure Disorder** | **Yes / No** | **High Cholesterol** | **Yes / No** |
| **Sleep Apnea** | **Yes / No** | **Stroke** | **Yes / No** | **Ulcer** | **Yes / No** |
| **Emphysema** | **Yes / No** | **Asthma** | **Yes / No** | **Heart Attack** | **Yes / No** |
| **Fibromyalgia** | **Yes / No** | **Phlebitis/Blood Clots** | **Yes / No** | **Cancer** | **Yes / No** |
| **Gout** | **Yes / No** | **Thyroid Diseases** | **Yes / No** | **Bleeding Disorder** | **Yes / No** |
| **Osteoarthritis** | **Yes / No** | **GERD/Reflux** | **Yes / No** | **Kidney Stone** | **Yes / No** |
| **Rheumatoid Arthritis** | **Yes / No** | **Depression/Anxiety** | **Yes / No** | **Hepatitis** | **Yes / No** |
| **Complications from Anesthesia** | **Yes / No** | | | | |

List any other conditions not mentioned above _____
_____
List all surgeries or hospital procedures _____
_____

Are you allergic to any medications? Yes / No List all Allergies to medications _____
_____

Are you allergic to LATEX? Yes / No _____ Are you allergic to TAPE? Yes / No _____

Please list all medications you are currently taking (including any Health Supplements and Homeopathic Treatments)

_____
_____
_____

**FAMILY HISTORY**

Please circle any significant health problems in your family history.

Heart Disease Diabetes High Blood Pressure Stroke Cancer

Other: _____

**SOCIAL HISTORY**

Alcohol use (type and frequency/amount)

Tobacco (amount and years used) _____

Occupation _____ Employer _____

**REVIEW OF SYMPTOMS** (Please write N/A beside any items that do not apply)

**Constitutional:** Fever, sudden weight loss/gain, loss of appetite _____

**Eyes:** Blurred vision, double vision, difficulty seeing _____

**Ear Nose Throat:** Deafness, sinusitis, hoarseness, vertigo tinnitus _____

**Cardiovascular:** Chest pain, palpitations, irregular hearbeat, murmur _____

Cardiologist Name and City _____

**Respiratory:** Shortness of breath, wheezing, chronic cough, spitting blood: _____

**Do you use:** CPAP or BiPAP

**Digestive:** Abdominal pain, constipation, diarrhea, bleeding _____

**Urologic:** Pain when urinating, hesitancy, bleeding, incontinence _____

**Gynecologic:** Breast masses, pain, discharge, problems _____

Last Gynecological checkup _____ Last Pap smear _____

**Skin:** Rashes, lesions that do not heal, changes in moles _____

**Neurological:** Seizures, loss of balance/coordination, paralysis, loss of memory _____

**Endocrine:** Excessive thirst, excessive urination, intolerance to heat/cold _____

**Blood and Lymphatic system:** Anemia, bleeding tendencies, swollen nodes _____

**Allergic and Immunologic:** Hives, eczema, itching _____

**Musculoskeletal:** Stiffness, joint pain, muscle wasting _____

**Other:** _____

_____

_____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____

Updated: _____ Updated: _____ Updated: _____

## AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopaedics 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 Sports Science & Orthopaedics 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 Sports Science & Orthopaedics 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 Sports Science & Orthopaedics, 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 Sports Science & Orthopaedics. I understand I am financially responsible for charges not covered by this assignment.

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

## WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Sports Science & Orthopaedics 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**_____

**(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.

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

# 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 692-3700 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 Community Hospital at Saints North 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

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My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date_____

(Signature of person financially responsible for payment)

Relationship if other than patient: _____

# *Oklahoma Sports Science & Orthopaedics*

- 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**_____