

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

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www.ossnetwork.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:			
				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
PATIENT'S ADDRESS:					Are You:		
					<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:			
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 _____ Form 200

Jimmy H. Conway, M.D.
New Patient Information Form

Name: _____ SS#: _____

Age: _____ Height: _____ Weight: _____

Primary Care Physician Name and Phone Number: _____ Referring Physician and Phone Number: _____

Reason for Today's Visit: _____

Is this injury related to work? _____ Auto Accident? _____

FILL OUT ALL BELOW AS YES OR NO

Past Medical History	YES	NO	Please <u>DETAIL ALL YES ANSWERS</u> below:
Eye, Ear, Nose, Throat problem	___	___	_____
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
Lung Disease	___	___	_____
Kidney/Liver Disease	___	___	_____
Stomach/Intestinal Disease	___	___	_____
Bone/Joint/Muscle Disease	___	___	_____
Diabetes	___	___	_____
Epilepsy	___	___	_____
Arthritis	___	___	_____
Cancer	___	___	_____
Vascular Disease	___	___	_____
Psychiatric Problems	___	___	_____
Anesthesia Problems	___	___	_____
HIV/AIDS	___	___	_____
Thyroid Problems	___	___	_____
Abnormal Bleeding	___	___	_____
Jaundice	___	___	_____
Hepatitis	___	___	_____
Mono	___	___	_____
Stroke	___	___	_____
CABG	___	___	_____
Abnormal Infections	___	___	_____
MRSA	___	___	_____
MRSE	___	___	_____
Anticoagulant Therapy (Blood Thinners)	___	___	_____
Alcohol Use	___	___	Amount/Duration: _____
Drug Use	___	___	Amount/Duration: _____
Tobacco Use	___	___	Amount/Duration: _____

IF NONE APPLIES, PLEASE INDICATE "NONE" BELOW

Family History of Above: _____

Past Surgical History: _____

Medications: _____

Allergies (please list all drugs/foods/dyes): _____

Prior Hospitalizations: _____

 Current Employment: _____
 Occupational History: _____
 Highest Level of Education: _____
 Recreational Activities: _____

FILL OUT ALL BELOW AS YES OR NO

SYSTEM REVIEW	YES	NO	If yes, please explain.
Headache, dizziness, visual disturbances	___	___	_____
Throat trouble, ringing in ears, runny nose	___	___	_____
Chest pain, palpitations, irregular heart beat	___	___	_____
Shortness of breath, cough	___	___	_____
Heartburn, nausea, vomiting, diarrhea	___	___	_____
Burning, frequency of urination or vaginal discharge	___	___	_____
Muscle, bone, joint pain or stiffness	___	___	_____
Changes in skin color, texture, moles or rashes	___	___	_____
Swellings, discolorations, temp. change of extremity	___	___	_____
Loss of sensation	___	___	_____
Lower back pain	___	___	_____
Fever, chills, sweats, fatigue	___	___	_____
Easy bruising or bleeding disorder	___	___	_____
Weight loss or gain	___	___	_____
Excessive thirst or hunger	___	___	_____
Excessive worry, anxiety, depression	___	___	_____
Dietary restrictions	___	___	_____
Glasses or contacts	___	___	_____
Dentures or partials	___	___	_____

WORKER'S COMPENSATION INFORMATION
 (Complete if applicable)

1. Date of work injury _____
2. Injured part the claim covers _____
3. Work title with description _____
4. Currently working (circle) YES NO
5. Current work restrictions _____
6. Last day worked _____

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.

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 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.

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

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring 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

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 your 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** _____

NEW PATIENT / NEW CONDITION HISTORY
SHOULDER

NAME _____

AGE _____

RIGHT/ LEFT HAND DOMINATE

WHERE DOES YOUR SHOULDER HURT? FRONT OF THE SHOULDER _____

BACK OF THE SHOULDER _____

RIGHT OR LEFT

SIDE OF THE SHOULDER _____

SHOULDER BLADE _____

NECK _____

IS THERE PAIN IN THE ARM, FOREARM, OR HAND? YES NO

IF YES, WHERE DOES IT HURT,

AND IS THERE NUMBNESS OR TINGLING? YES NO

IF YES, WHERE DOES IT NUMB OR
TINGLE? _____

WHEN DID THE PROBLEM
START? _____

IS IT DUE TO AN INJURY? YES NO

IF YES, WHAT
HAPPENED? _____

HAVE YOU BEEN TREATED BY ANOTHER HEALTHCARE PROVIDER? YES NO

IF YES, WHAT WAS DONE? INJECTIONS, THERAPY OR TESTING (MRI, CT, MR
ARTHROGRAM), AND WHO PROVIDED THIS
TREATMENT? _____

HAS SURGERY BEEN PERFORMED ? YES NO

IF YES, WHO PERFORMED IT, AND WHEN, AND
WHERE? _____

WHAT PROCEDURE WAS PERFORMED?

DID THE SURGERY HELP? WAS IT SUCCESSFUL?
