Oklahoma Sports & Orthopedics Institute

Patient and Insurance Information

Please complete all fields

Patient Name: _____ Preferred Name: _____ Sex: _____

Patient Date of Birth: _____ Patient SSN: _____

Mailing Address: _____
Street Apt

_____
City State Zip Code

Patient Phone: Home: _____ Email: _____
Work: _____ Occupation: _____
Cell: _____ Employer: _____

Guarantor Name: _____ Sex: ☐ Male ☐ Female
Guarantor Date of Birth: _____ Guarantor SSN: _____

Emergency Contact: _____ ( ) _____
Name Relationship Phone

Primary Insurance Company Name: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Personal ID#: _____ Group #: _____

Secondary Insurance Company Name: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Personal ID#: _____ Group #: _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White ☐ Declined

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type-Unknown ☐ Declined

Preferred Language: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize Oklahoma Sports and Orthopedics Institute to release information contained in my medical record including information regarding scheduled appointments, medications, and/or billing on my account to the following individuals.

Name: _____
Relationship

Name: _____
Relationship

Name: _____
Relationship

_____ _____
Patient or Legal Guardian Signature Date

BC1

Oklahoma Sports & Orthopedics Institute

General History Information

Please complete all fields

Ht:_____ Wt: _____ ☐ Left Handed ☐ Right Handed

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. It is very important that you clearly tell us your past medical background as this assists the physicians in understanding your problem and executing the best care and outcome for your current condition.

HOW DID YOU HEAR ABOUT OSOI?

☐ Physician Name: _____ Physician Phone: _____

☐ Athletic Trainer: _____
Name School

☐ Friend/Family: _____ ☐ Phone Book ☐ www.OSOI.com ☐ Other _____

HISTORY OF THE PRESENT CONDITION

Primary Care Physician: _____ Physician Phone: _____
Phone

Why are we seeing you today? ☐ Left ☐ Right _____

How long have you had this problem? _____

When did this occur? _____ Have you had this problem before? ☐ Yes ☐ No

Was this an auto injury (accident)? ☐ Yes ☐ No

Is your injury work/job related?
if work related please complete
Worker's Compensation Questionnaire ☐ Yes ☐ No

What makes the condition worse? _____

What makes the condition better? _____

Describe in detail how the injury occurred:

_____

_____

For this injury or condition, which have you had in the past 12 months?

☐ Bone Scan	☐ Blood Tests	☐ MRI	☐ CT Scan
☐ EMG/Nerve Test	☐ Myelogram	☐ X-Rays	☐ Pain Clinic
☐ Steroid Shots	☐ Phys. Therapy	☐ Brace/Corset	☐ Taken Medication

☐ Other _____

Mark if allergic to:

☐ Metals ☐ Latex ☐ Iodine ☐ IVP Dye ☐ Steroids ☐ Aspirin

Oklahoma Sports & Orthopedics Institute

General History Information

Please complete all fields

Allergies to Medications, Foods, or Other Substances

Please list allergies and indicate reaction:

_____

_____

CURRENT MEDICATIONS

Please list all prescription and over-the-counter medicines you are taking:

Pharmacy Name: _____ Phone: _____

Address/Cross Street: _____

In which items have you recently participated?

☐ Daily Exercise ☐ Lost Weight ☐ Quit Smoking ☐ Swimming ☐ Biking

☐ Metal Implants ☐ Infusion Catheters ☐ Surgical Clips ☐ Pacemaker

SOCIAL HISTORY

Select the appropriate box.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment: ☐ Employed ☐ Seeking Work ☐ Disabled ☐ Retired

Exercise: ☐ Never ☐ Mild ☐ Moderate ☐ Vigorous

Nicotine: ☐ Current Everyday ☐ Current Someday ☐ Former ☐ Never

Smoking History: ☐ Current Everyday ☐ Current Someday ☐ Former ☐ Never

Smoking Status: ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Date Started Smoking_____

Alcohol: ☐ Current Everyday ☐ Occasional ☐ Frequently ☐ Never

Pregnant: ☐ Yes ☐ No ☐ Planning

My Health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I am currently living in a/an: ☐ Skilled Nursing Facility ☐ Assisted Living Center ☐ N/A

Name of Facility Address Phone

Oklahoma Sports & Orthopedics Institute

General History Information

Please complete all fields

Name: _____ Date of Birth: _____

REVIEW OF SYMPTOMS

Please check Yes or No for each system listed below

CONSTITUTIONAL SYMPTOMS	YES	NO
Are you in good general health	○	○
Recent weight change	○	○
Fever	○	○
Fatigue	○	○

EYES	YES	NO
Wear glasses or contacts	○	○
Blurred or double vision	○	○
Glaucoma	○	○

EARS/NOSE/MOUTH/THROAT	YES	NO
Hearing loss or ringing	○	○
Earaches or drainage	○	○
Chronic sinus problem or rhinitis	○	○
Nose bleeds	○	○
Swollen glands in neck	○	○
Sleep apnea	○	○

CARDIOVASCULAR	YES	NO
Heart trouble	○	○
Chest pain	○	○
Palpitation	○	○
Shortness of breath	○	○
Swelling of feet, ankles, hands	○	○

RESPIRATORY	YES	NO
Chronic or frequent coughs	○	○
Wheezing/ Shortness of Breath	○	○

MUSCULOSKELETAL	YES	NO
Neurologic Headaches	○	○
Seizures	○	○
Numbness/Tingling	○	○
Joint pain	○	○
Difficulty walking	○	○
Joint stiffness or swelling	○	○
Weakness of muscles or joints	○	○
Muscle pain or cramps	○	○
Back pain	○	○
Recent Fall	○	○

SKIN	YES	NO
Rash or itching	○	○
Change in skin color	○	○
Varicose veins	○	○

ENDOCRINE	YES	NO
Thyroid disease	○	○
Excessive thirst or urination	○	○
Heat or cold intolerance	○	○

Vaccine	YES	NO	Date
Pneumonia	○	○	_____
Flu	○	○	_____

HEMATOLOGICAL/LYMPHATIC	YES	NO
Slow to health after cuts	○	○
Bleeding or bruising tendency	○	○
Anemia	○	○
Phlebitis	○	○
Past transfusions	○	○

REVIEW OF SYMPTOMS (CONTINUED)

Select the box if you have experienced any of the following in the last 2 weeks.

GASTROINTESTINAL	YES	NO	PSYCHIATRIC	YES	NO
Loss of appetite	○	○	Memory loss or confusion	○	○
Change/pain in bowel movements	○	○	Nervousness	○	○
Nausea or vomiting	○	○	Depression	○	○
Abdominal pain or heartburn	○	○	Insomnia	○	○

PAST MEDICAL HISTORY

Select the box if you have had any of the following problems.

- ☐ Coronary Artery Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Blood Vessel Disorder
- ☐ COPD/Asthma
- ☐ Stroke/Blood Clots
- ☐ Neurological Problems
- ☐ Depression
- ☐ Incontinence
- ☐ Abnormal EKG
- ☐ Kidney Disease/Stones
- ☐ Prostate Problems
- ☐ Thyroid Disease
- ☐ Stomach Ulcers
- ☐ Gastro-Intestinal Reflux
- ☐ Liver Problems/Hepatitis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Lung/Breathing Problems
- ☐ Abnormal Chest X-Ray
- ☐ Cancer - _____
- ☐ Allergy to Anesthesia
- ☐ Drug/Alcohol Addiction
- ☐ Ear, Nose, Throat Problems
- ☐ Sleep Apnea/CPAP
- ☐ Osteoporosis
- ☐ Arthritis - _____
- ☐ HIV/AIDS
- ☐ Anemia/Blood
- ☐ Other: _____

PAST SURGICAL HISTORY

Year	Procedure	Surgeon	Location

FAMILY MEDICAL HISTORY

Select the box if you any of the following exist in your family or relatives.

- ☐ Arthritis
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Neurological Problems
- ☐ Peripheral Vascular Disease

Workers' Compensation
Patient Questionnaire

Name _____ Date of injury _____
Is your current condition/injury work related? ○ Yes ○ No If yes, please explain in detail how it occurred.

Are you currently working for an employer? ○ Yes ○ No Have you worked since your injury? ○ Yes ○ No

Are you considered either self-employed or contract labor? ○ Self-employed ○ Contract labor
Have you signed a waiver releasing your employer from any workers compensation liability? ○ Yes ○ No

Has your employer been notified of this injury? ○ Yes ○ No Has a Form 3 been filed for this injury? ○ Yes ○ No

Employer _____ Contact Person _____

Phone _____ Address/Location _____

Workers' Comp Insurance Carrier _____

Claims Adjuster _____ Phone _____

Claim Number _____ Length of time with employer _____

Are you currently represented by an attorney? ○ Yes ○ No

Name _____ Phone _____

Circle all body parts injured: Head Neck Back (Upper) (Lower) Shoulder (Left) (Right)
Arm (Left) (Right) Wrist (Left) (Right) Leg (Left) (Right) Knee (Left) (Right)
Foot (Left) (Right) Other, please describe _____

How did your symptoms begin? ○ Suddenly ○ Gradually If gradually, over what time period? _____

Is there anything you cannot do now that you could prior to your injury? Ex: sports, hobbies, house/yard work

**Please note it is important to establish complete and accurate information regarding your workers compensation case in order to establish appropriate and timely care. Your cooperation is sincerely appreciated*

I certify that the above information is true and correct to the best of my knowledge.

Patient Signature **Date**

Oklahoma Sports & Orthopedics Institute

Contract for Narcotic Prescriptions

Ted Boehm, MD • Jim Bond, MD • Brian Clowers, MD • Scott de la Garza, MD
Timothy Geib, MD • Richard Kirkpatrick, MD • Zakary Knutson, MD • Seethal Madhavarapu, MD
Corey Ponder, MD • Scott Waugh, MD

Controlled substance medications (Narcotics, Opiates, Tranquilizers, and Barbiturates) can be useful to treat some painful conditions, but have a high potential for misuse and abuse and are therefore closely controlled by the government. If used excessively, they can cause adverse effects such as impaired judgment, vomiting, constipation, lethargy and even death. To ensure that these medications are used properly to treat my pain, ***I agree*** to follow the instructions listed below. ***I understand*** that if I do not abide by these instructions and conditions, the prescribing of ***my narcotic pain medication and my entire treatment at Oklahoma Sports and Orthopedics Institute will be discontinued.***

1. ***I am responsible for my narcotic medication.*** They are like money, in the sense that, if the prescription or the medication itself is lost, misplaced or stolen, or if I run out too soon, **the medication is gone and will not be replaced**. I will not increase the dose (take more than prescribed) of my medicine without first discussing it with the physician. Requests for early refills will be denied and if the requests continue, my treatment with Oklahoma Sports and Orthopedics may be terminated.
2. ***Refills of narcotic medication will be made only during business hours.*** Narcotic refills are filled Monday-Thursday 8:30a.m.-4:00p.m. Refill requests will not be taken on Fridays. When requesting refills please have the pharmacy fax a refill request to your doctor. Refills of narcotic medications will not be made after hours, on the weekends or on holidays. The answering service will not contact the doctor for refills. It is my responsibility to contact the office 24-48 hours prior to using the last of my medicine to ensure that I do not run out. I understand that stopping my medicine supply may be dangerous to my health and cause serious withdrawal symptoms. I understand that narcotic prescriptions may be required to be picked up and a photo ID will be required before the prescription will be released. If a person other than me will pick up the prescription, that person will be required to bring his/her photo ID and a note from myself authorizing my medication to be released.
3. ***I will not request nor accept narcotic medication from any other physician and/or other individual while I am receiving such medication from this office.*** If I must go to the emergency room and/or hospital for any actual emergency and if at that time I am given a narcotic prescription, I will notify this office within 24 business hours. ***I understand that it is ILLEGAL to obtain narcotic medication from multiple physicians. It is also illegal to accept medications from other individuals or to share my medicine.***
4. ***I understand my physician will discuss narcotic effects,*** including normal physiological effects of tolerance (need for more medicine to achieve the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking the medicine abruptly) and/or the abnormal effect of addiction (psychological dependency leading to abnormal behavior), which is very rare in patients with genuine pain. Narcotics can adversely affect my business decisions and capabilities of operating equipment, such as an automobile.
5. ***I understand that if I violate ANY of the above instructions or conditions, or if I decline at any time when requested by my physician to take a blood or urine test for controlled drug screening (at my own expense) MY NARCOTIC PRESCRIPTIONS AND MY ENTIRE TREATMENT AT OKLAHOMA SPORTS AND ORTHOPEDICS INSTITUTE MAY BE TERMINATED IMMEDIATELY. Any violation of this contract will be reported to any other physician and to local medical facilities involved in my care. Any violations of State or Federal Law will be reported to the authority.***

Patient Signature _____ Date _____

Oklahoma Sports & Orthopedics Institute

Patient Financial Policy

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.

If your injury was due to a Motor Vehicle Accident or any other "Third Party Liability" accident, you will be set up on a self-pay account requiring a down-payment of $500.00.

ADDITIONAL CHARGES

There is a $20.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion. There is a $20.00 charge for any returned check. This charge is applicable per returned check. Returned checks may be submitted to the District Attorney's office. **There may be a $20.00 charge accessed to your account for No-Showing an appointment or for cancellations within 24 hours of your scheduled appointment.**

CREDIT COLLECTIONS INC. (CCI)

In the interest of good business practice, the desire to continue to provide quality health services and maintain fiscal responsibility, Oklahoma Sports & Orthopedics Institute has developed a policy regarding partial and non-payment for outstanding accounts. You are responsible for payment of all medical treatment and related services provided by Oklahoma Sports & Orthopedics Institute. As a service and out of consideration to you, this office will file insurance claims for all covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance company's maximum allowable reimbursement. **You will be responsible for any deductible, co-insurance or co-payment amounts and any non-covered services incurred at the time of service. All accounts are considered due after payment from insurance company is received.** Payments can be made by cash, check, money order, Visa, MasterCard, American Express, or Discover card. 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.

In keeping with our commitment to serve our patients, Oklahoma Sports & Orthopedics Institute may allow payment plans or may set up recurring debit or credit card transactions. The Oklahoma Sports and Orthopedics Institute billing procedure is as follows:

A) Initial balance due will be sent to the patient for an attempt to collect the balance in full.
B) In the event payment in full is not received by Oklahoma Sports & Orthopedics Institute within 30 days of said statement, the following may automatically occur:
   1) This amount and any future balances due will be handled by our collection agency, Credit Collections, Inc. (CCI)
   2) Credit Collections, Inc. is a national debt collection agency. If the balance is not satisfied in full within 90 days, your account may automatically be reported to all three credit bureaus.

Again, thank you for allowing Oklahoma Sports and Orthopedics Institute to participate in your care.

Sincerely,

OSOI Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signature Relationship Date

Oklahoma Sports & Orthopedics Institute

Authorization & Assignment

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Sports and Orthopedics Institute to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

I agree that Oklahoma Sports & Orthopedics Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Sports and Orthopedics Institute 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 and Orthopedics Institute 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 and Orthopedics Institute, its agent and its employees from liability in connection with the release of the information contained therein.

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 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.

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 and Orthopedics Institute. **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 and Orthopedics Institute 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.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you would like to receive a copy of this full notice please ask the front desk. By signing below you acknowledge that you can receive a full copy of our privacy practices.

SIGNED _____ **DATE** _____

PATIENT

OR _____

NEAREST RELATIVE OR RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT**