

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

6205 North Sante Fe • Oklahoma City, Oklahoma 73118 • (405) 427-6776 • FAX (405) 419-5475

J. Calvin Johnson, M.D. • Robert F. Hines, M.D. • Jimmy H. Conway, Jr., M.D. • Michael O. Williams, M.D. • Thomas C. Coniglione, M.D. • Robert S. Unsell, M.D.
 Steve D. Coupens, M.D. • Michael H. Wright, M.D. • William A. Herndon, M.D. • Michael J. Carl, M.D. • G. David Casper, M.D. • Arthur H. Conley, M.D.
 Darryl D. Robinson, M.D. • Don E. Adams, M.D. • Hal D. Martin, D.O. • Gregory J. Zeiders, D.O. • Barry L. Northcutt, M.D.

NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST		FIRST		MIDDLE INITIAL	SEX:	BIRTH DATE:	AGE
SOCIAL SECURITY NO.:		EMAIL ADDRESS			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:		Is it okay to leave a message on phone number provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
{ }		{ }		{ }			

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# _____

EMERGENCY CONTACT

NEAREST RELATIVE 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 A Motor Vehicle 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 _____

Sheri M. Smith, M.D.

Orthopedic specialist for foot/ankle

Chief complaint/reason for visit summary

Patient name: _____ **DOB** _____ **Date** _____

- Who is your primary care physician? _____
- Who is your Cardiologist? _____
- Preferred pharmacy
name _____
Phone number _____
Address/cross streets _____

• **Height** _____ **Weight** _____

- What body part/extremity are you being seen for today? RT/LT/BOTH _____
- How long have you had this injury? _____
- Is this injury a work-related injury? YES NO

If Yes:

date injury occurred _____ has a claim been filed for this injury? YES NO

- Is this injury due to a motor vehicle accident? YES NO

If Yes:

date injury occurred _____ Has a claim been filed for this injury YES NO

- Please describe how you sustained this injury

- Any other primary concerns you would like to discuss with Dr. Smith during your visit today?

Sheri M. Smith, M.D.

Orthopedic specialist for foot/ankle

Medical History Form

Review of systems

○ Are you experiencing any of the following symptoms:

___ Excessive weight
gain/loss

___ Dizziness

___ Ringing in the ears

___ Snoring

___ Shortness of breath

___ Chest pain

___ Palpitations

___ Anxiety

___ Depression

___ Headaches

___ Seizures

___ Syncope

___ Heart attack

___ Heart disease

___ High blood
pressure

___ Atrial fibrillation

___ Asthma

___ COPD

___ Emphysema

___ Acne

___ Rash

___ Reflux

___ Heartburn

___ Ulcers

___ Diverticulitis

___ Liver disease

___ Hepatic failure

___ Arthritis

___ Gout

___ Broken bones

___ Prostate issues

___ Anemia

___ Diabetes

___ Type 1

___ Type II

___ gestational

___ Thyroid issues

___ Stroke

___ Headache

___ Migraine

___ Dementia

___ Endometriosis

___ HPV

___ Cancer

Type_____

Social History

- Tobacco
 - ___ Never
 - ___ Former
 - Date quit _____
 - ___ Current
 - ___ Light tobacco smoker
 - ___ Heavy tobacco smoker
- Alcohol use: YES NO
 - #drinks _____ per day /week /occasional (*Please circle one*)
- Occupation _____

Family History

Condition	Family member
Asthma	
Heart disease	
Heart failure	
High blood pressure	
Migraine	
Osteoporosis	
Stroke	
Thyroid issues	
Cancer:	
Other:	

Please list any radiology procedures (XRAYs, MRI, CT) specific to the reason you are here today

Type of procedure	Date performed

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

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
(NEAREST RELATIVE OR TO SIGNATURE
RESPONSIBLE PARTY)

(RELATIONSHIP TO PATIENT) POLICYHOLDER'S
SIGNATURE _____

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 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 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 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 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 _____

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. Sheryl Smith, M.D. has an ownership interest in Community Hospital and Northwest Surgical Hospital. SSM Health Care of Oklahoma d/b/a St. Anthony Hospital is also a proud affiliate of 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.

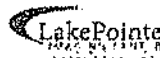
Signature of Patient

Signature of Parent or Guardian
(if applicable)

Print Name of Patient

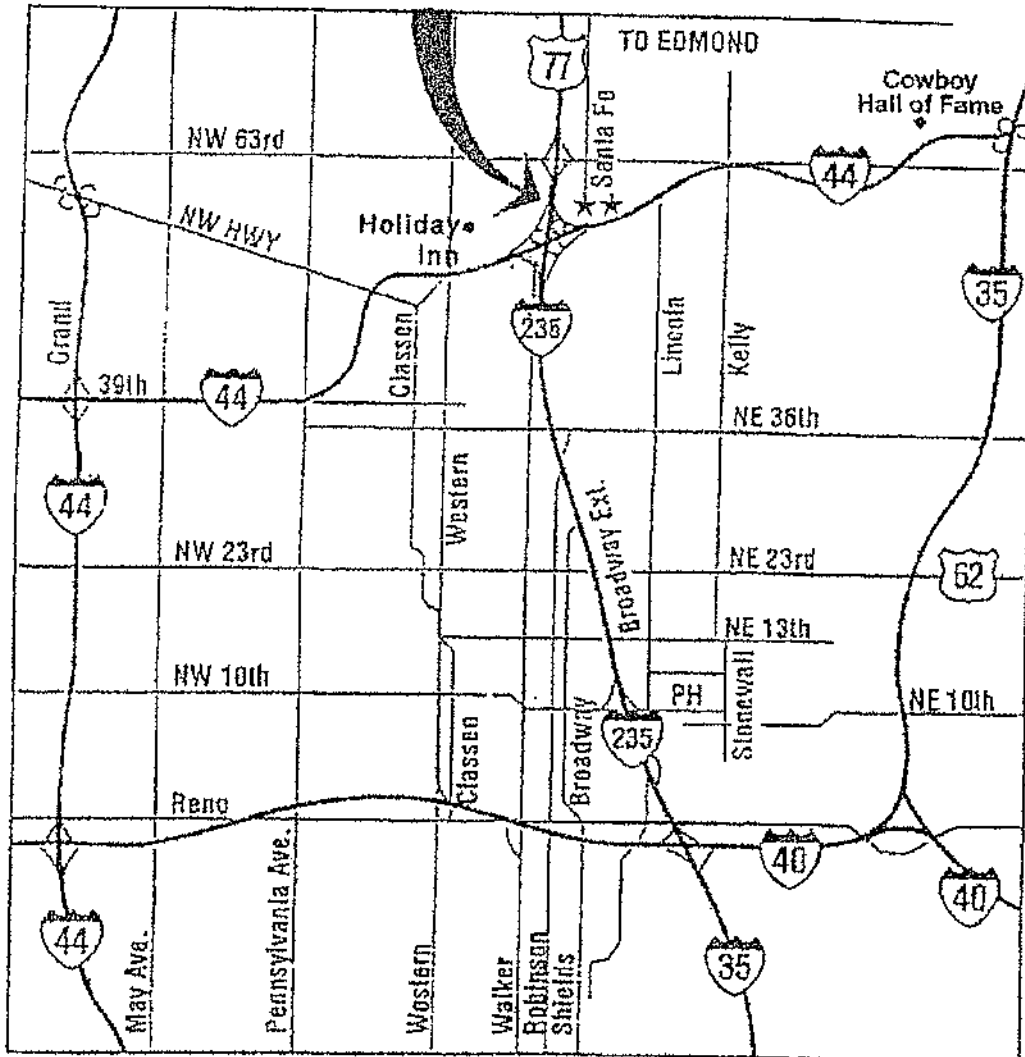
Print Name of Parent or Guardian

Dated: _____



Oklahoma Sports Science and Orthopaedics

Specializing in general orthopedic, orthopedic surgery, fractures, trauma, arthroscopic surgery, sports medicine and laser surgery.



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