OSSO
AN HPI AFFILIATE

9800 Broadway Ext. • Oklahoma City, OK 73114 • Phone 405.330.8847

PATIENT INFORMATION

(Please Print – Fill in All Blanks)

Patient's Legal Name: Last	First	M.I.	Sex:	DOB:	Age:

Social Security Number:	Marital Status: ____ Single _____ Married _____ Widowed _____ Divorced _____Separated
Patient's Address:	Employment Status: ____ Employed _____ Full-time student _____ Part-time student _____ Retired

City:	State:	Zip Code:	Email:	Referring Physician:

Home Phone:	Work Phone:	Cell Phone:

Ethnicity: ___Hispanic ___Non-Hispanic ___Declined	Race: __White __Asian __Black __Pacific ___ Native American __Multiple __Other	Preferred Language:

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim.

Name of Primary Insurance Company	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

Secondary Insurance (if applicable)	
Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

EMPLOYMENT INFORMATION

Patient's Employer	Phone Number
Insured Employer	Phone Number

If the patient is a minor, please list both parent names and employers

Mother	Employer	Phone Number
Father	Employer	Phone Number

NEXT-OF-KIN INFORMATION

Nearest relative (or friend, not spouse), not living with you:	
Home Phone:	Relationship to Patient:

WHO REFERRED YOU TO OUR OFFICE? (circle one)

Adjustor	Attorney	Billboard	Case Manager	Doctor	Employer	Friend	Hospital	Insurance
Magazine	Neighbor	Phone Book	Physical Therapist	Coach	Radio	School	Trainer	Other

THIRD PARTY BILLING (circle one)

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 to be paid directly to the facility and the physician. I acknowledge that 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 & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

Chart No. _____

OKLAHOMA SPORTS SCIENCE & 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 voicemail 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 plans, 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 that 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

- 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**_____

The Physicians' Group, LLC
HPI Physicians, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices:

- The Notice tells me how The Physicians' Group, LLC or HPI Physicians, LLC, as applicable, will use protected heath information for the purposes of treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient's Name (print):_____

Patient's Date Of Birth:_____

****THIS FORM MUST BE SIGNED BY EITHER THE PATIENT OR BY THE PATIENTS'S PERSONAL REPRESENTATIVE.****

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patients:

_____

_____

_____

Signature of Patient or Patients Representative: _____

Date:_____

Current Contact Information for Patient or Personal Representative signing this form:

Name (print): _____

Address: _____

Telephone Number: _____

Email: _____

**** This form should be placed in the patient's medical record.****

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

A DIVISION OF THE PHYSICIANS' GROUP

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopaedics (OSSO) are you healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost-effective care. We specialize in adult and pediatric orthopedics, sports medicine, running injuries, physical medicine and rehabilitation, pain management, reconstructive and orthopedic spine surgery and hand surgery.

In addition to accepting traditional insurance plans and Medicare we are contracted with numbers 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 your current insurance card, or any other information that is required by your insurance company to each appointment. 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, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at XXX-XXXX to make financial arrangements. Please be aware that charge 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 (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, 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 charge any FMLA, disability or accidental form completed. This charge is applicable per form completed any is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital 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, than you for allowing Oklahoma Sports Science & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed_____ Date_____

(signature of person financially responsible for payment)

Relationship if other than patient_____

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 and Orthopaedics, its agents and its 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 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 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 healthcare 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 Dept. of Health, or by law.

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

Today's date: _____ Weight: _____ Height: _____

Medical History Form

Review of Systems

Are you experiencing any of the following symptoms?

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

Skin:
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives
- ☐ Jaundice
- ☐ Rash

HEENT:
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Visual Changes
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Postnasal Drainage
- ☐ Sinus Pressure
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat

Respiratory:
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Difficulty Breathing on Exertion
- ☐ Palpitations
- ☐ Swelling of Extremities

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Groin Pain
- ☐ Incontinence
- ☐ Pelvic Pain
- ☐ Urgency

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Stiffness
- ☐ Ambulatory Support
- ☐ Pain with Stairs
- ☐ Developing Limp
- ☐ Trouble Dressing
- ☐ Locking
- ☐ Clicking/Catching
- ☐ Instability

___ Blocks able to walk

Neurologic:
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures
- ☐ Syncope
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble Focusing

Endocrine:
- ☐ Excessive Thirst
- ☐ High Blood Pressure
- ☐ Low Blood Pressure

Hematology:
- ☐ Abnormal Bleeding
- ☐ Enlarged Lymph Nodes

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

Past Medical History

☐ Anesthetic Complications
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Fibromyalgia
☐ GERD/Reflux Disease
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ Hyperlipidemia
☐ Kidney Stone
☐ MRSA
☐ Osteoarthritis
☐ Phlebitis
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ Ulcers
☐ Chronic Pain

Social History

Tobacco: ☐ Never a Smoker
Current Smoker: Cigarettes ☐ Yes ☐ No Amt:_____pck/day Has been smoking for? Smokeless Tobacco ☐ Yes ☐ No Amt:_____per day
Cigars ☐ Yes ☐ No Amt:_____# week
☐ Quit Smoking; Year last smoked _____ Amt: _____pck/day How many years did you smoke?_____
Alcohol use:☐ Yes ☐ No _____# drinks per day / week / occasional / social
Exercise: ☐ Yes ☐ No Times per week: _____ Type of exercise: _____
Occupation: _____

Family History

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

☐ Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other	☐ Father	☐ Mother	☐ Sibling	☐ Other_____

List all **ALLERGIES** to any **MEDICATIONS, METALS, LATEX, or TAPE and the reactions:**
☐ **No Known Drug Allergies**

Medications / Metals / Other	Reaction

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

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: _____
☐ None

Past Surgical History

Please 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: Xray, MRI, CT scan)

Radiology Procedure	Year	Radiology Procedure	Year

Have you or an immediate family member ever had a history of a blood clot? ☐ Yes ☐ No
If yes, please explain below

_____
_____
_____

Do you have an allergy or sensitivity to metal? ☐ Yes ☐ No
If yes, please explain below

_____
_____
_____

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

Please provide **first & last** names of all other physicians that you currently see and their specialty:

_____

_____

Are you here for a second opinion? _____

Were you injured on the job? _____

If yes, how did it happen? _____

_____

_____

Where? _____

What Time/Date? _____

*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):

_____

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Appointment No Show and Late Policy

Appointment No Shows:

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than the Friday prior to your appointment.

- The first no show will result in a call or email reminding you that you have missed your appointment and will need to reschedule for another day.
- The second no show will result in a call or email and a $50.00 charge to the patient, not your insurance company. This MUST BE paid prior to scheduling your next appointment.
- The third no show will result in a dismissal from the practice.

Late Policy:

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day. If you are late to your appointment, but do not call us prior to the appointment time, we will give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Post-operative patients arriving 10-30 minutes late will be seen, but will have to wait while we see patients who arrived to their scheduled appointment on time.
- Non Post- Operative patients arriving 10-30 minutes late will be asked to reschedule.
- ANY patient arriving more than 30 minutes late will be asked to reschedule.

_____ _____

Signature of Patient Signature of Parent or Guardian

_____ _____

Print Name of Patient Print Name of Parent or Guardian

_____

Dated

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. Ryan L. Nelson, D.O. has an ownership interest in 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

Date:_____

HPI
COMMUNITY
HOSPITAL

HPI
NORTHWEST
SURGICAL
HOSPITAL

HPI
COMMUNITY
HOSPITAL
IMAGING CENTER

HPI
COMMUNITY
HOSPITAL
OUTPATIENT THERAPY

HPI
NORTHWEST
SURGICAL
HOSPITAL
LAKEPOINTE IMAGING CENTER