OKFootMD ORTHOPEDIC SPECIALISTS

OSSO AN HPI AFFILIATE

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 Unemployed 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:**
If the patient is a minor, please list both parent names and employees	

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 (check one)

Is your injury work related?	**YES**	**NO**
Is your 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:**

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 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 SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including my information concerning identity, and release Oklahoma Sports Science & 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 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 or jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ **DATE** _____
(PATIENT)

OR _____
(NEAREST RELATIVE OR 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 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 and Orthopaedics
Authorization to Release Information via phone / Family / Friends

Patient Name: _____ **DOB**: _____ **Chart #:**_____

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: _____ **Work**: _____ **Cell**: _____

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

PATIENT-PROVIDER AGREEMENT AND INFORMED CONSENT
ACUTE PAIN

1. Your treating physician has prescribed you opioid pain medication as part of your treatment plan to manage your acute pain. Your treatment plan also includes the following alternatives:
   _____.
2. The pain you are experiencing may be improved, but not eliminated, with the use of these opioid medications. Opioids are a type of powerful pain medication often called narcotics. They can be very useful in managing pain, but have a high potential for dependency and addiction.
3. Once opioid pain medications are prescribed, you will be required to have regular office visits to assess your pain status and monitor your compliance with this agreement. Your medications will not be phoned in should you be unable to keep these appointments.
4. Pain medications are strictly for your own use. The medication should not be given or sold to others because it may endanger that person's health and it is against the law.
5. 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.
6. Your treating physician is to be the only physician who prescribes opioid pain medications to you.
7. It is your responsibility to notify us of any other physician who is prescribing opioid pain medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing your opioid pain medications.
8. 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 opioid pain medications will not be refilled, and you will be dismissed as a patient.
9. 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.
10. Pain medication refill request are taken, and called in MONDAY through Friday from 8:30AM to 3:30PM ONLY. **PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS OR AFTER HOURS FOR ANY REASON.**
11. Opioid medications carry a high potential for abuse and addiction. Therefore, federal and state law carefully regulates dispensed or written prescriptions for opioid medications. Forging or altering an opioid prescription, or distribution medications to others for their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and reported to appropriate authorities.
12. Lost, stolen or misplaced prescription medications ARE NEVER REPLACED – NO EXCEPTIONS. Your medications and prescriptions are your responsibility. You should store opioid medications in a secure location to prevent others from taking them and safely dispose of them when you are no longer using them.
13. There are several risks of opioid medications that your treating physician has discussed with you. Some of those risks include sleepiness or drowsiness, impaired mental or motor ability, slowing of breathing rate, skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, swelling, physical or psychological dependence, tolerance to analgesia (meaning you require more medicine to get the same pain relief), and addiction. Opioid medications are highly addictive even when taken as prescribed. Overdose of opioid pain medication can lead to breathing difficulty and even death. Taking more opioid medication than prescribed or mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system

depressants is highly dangerous and can be fatal. It is your responsibility to inform your treating physician about all other medicines you are taking.

14. You should not drive an automobile or operate any machinery when taking opioid medications.
15. Your treating physician has discussed with you alternative pain management approaches that may be available to manage your pain instead of taking opioid pain medications and the risks and benefits of the alternatives.
16. If you break any of the rules described in this agreement, or your physician decides that the medicine is hurting you more than helping you, this medicine will be stopped by your physician in a safe way and no refills will be made. Further, your physician may dismiss you as a patient of the practice and ask you to select another physician. Any violation of this agreement or counseling received regarding violations will remain a part of your permanent medical record. This agreement will remain enforced during the entire course of your treatment plan.

INFORMED CONSENT

I, _____, have been informed and clearly understand the above listed issues regarding the treatment of pain with opioid pain medications. I have talked about this agreement with my doctor and I understand the above rules. I understand that this agreement will be filed in my chart as part of my permanent medical record.

Signature of Patient: _____ Date: _____

Signature of Physician: _____

If the patient is a minor, the patient's parent or guardian must consent by signing below.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

New **State Law** Regarding Narcotic Prescriptions
House Bill 2931
Effective January 1, 2020

Due to a new State of Oklahoma law, all narcotic medications MUST be sent to pharmacies in electronic form ONLY. Written narcotic scripts are no longer acceptable under this new law.
Please provide your pharmacy information below. **This is the only pharmacy we will use for your medications.**
If you need a refill, you will be required to contact our office 48-72 hours in advance. **NO REFILLS WILL BE GIVEN ON FRIDAYS**. Since our physicians are often in surgery and not in the clinic setting, same-day or next day refills **cannot** be guaranteed.

Pharmacy Name:_____
Pharmacy Address:_____
_____
Pharmacy Phone Number:_____

Confirm the above information is correct. As this is where you will be required to pick up your prescription.