Please <u>read and initial</u> the following statements:

It is important that you follow the guidelines listed below in order to help ensure you are seen in a timely manner and that correct data regarding your visit is obtained.

_____The first thirty to forty-five minutes of your appointment will be spent with check-in, insurance, paperwork, and x-rays. **At minimum, you should allow two (2) hours for your first visit.**

_____It is mandatory that you bring all **current insurance cards**, **forms**, **driver's' license**, and **necessary referral letters** with you at the time of your appointment. This allows for proper billing and insurance approval.

_____If you cannot make your appointment, we respectfully ask that you notify our office twenty-four (24) hours in advance. **A $25 no-show fee will be imposed for any appointment that is not canceled with a 24-hour notice.** Repeatedly not showing for your scheduled appointments may result in being discharged from the practice.

_____If you are late for your appointment, please call ahead and notify our office. If you arrive fifteen (15) or more minutes late, you may be required to reschedule for a different date and time.

_____Prior imaging and operative reports relative to the injury should be brought the day of your appointment. **Please bring reports <u>only</u>. We will not accept any CDs.**

_____You may be asked to change into a gown and/or shorts for your exam. For your comfort, you may choose instead to follow these recommendations (be mindful that there could be instances when you will be asked to wear a gown/shorts):

-**<u>Knee Exams</u>**: Wear or bring loose-fitting, non-denim shorts (no snaps, buttons, zippers, or plastic).
-**<u>Hip Exams</u>**: Wear or bring non-denim shorts, sweatpants, athletic pants, or pull on type pants (no snaps, buttons, zippers, plastic, or metal grommets, embroidery or screen printing).
-**<u>Back Exams:</u>** Wear or bring non-denim pants and a sports bra (no snaps, buttons, zippers, plastic or metal grommets, screen printing, or embroidery).
-**<u>Shoulder Exams</u>**: Wear or bring a t-shirt and sports bra (no snaps, buttons, or underwire).

Pre-registration allows us to validate your demographics and insurance more quickly during your visit. This saves you time in the waiting room and helps us move your appointment along more quickly! **Please complete the following paperwork, along with this cover sheet, and email or fax it at least two days prior to your appointment.** If possible, please also scan a legible copy of your insurance card(s) and driver's license along with your forms (please send scans only-- no photos!).

Fax: (405) 513-7739
Email: frontdesk@hargrovemd.com

If it is less than twenty-four (24) hours before your appointment, please bring your registration paperwork with you instead of emailing or faxing it; our office needs twenty-four (24) hours to process registrations that are faxed or emailed.

Patient Name (Print) Date of Appointment

Patient Signature Date of Signature

NAME: _____ **PREFERRED NAME**: _____
LAST FIRST M.I.

DATE OF BIRTH: _____ **SSN**: _____-_____-_____ **MALE**: _____ **FEMALE**: _____

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

HOME #: _____ **CELL #**: _____ **EMAIL**:_____

EMERGENCY CONTACT: _____ **CONTACT #**: _____
NAME RELATION

MARITAL STATUS: ☐ SINGLE ☐ ENGAGED ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LIFE PARTNER

NAME OF SPOUSE: _____ **CONTACT #**: _____

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ UNEMPLOYED ☐ FULL TIME STUDENT

EMPLOYER: _____ **PREFERRED LANGUAGE**: _____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO ANSWER

RACE (MARK ONE OR MORE): ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐ DECLINE TO ANSWER

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE**: _____
POLICY HOLDER'S NAME: _____ POLICY HOLDER'S NAME: _____
RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ SSN: ____-___-_____ DATE OF BIRTH: _____ SSN: ____-___-_____
ID #: _____ GROUP #: _____ ID #: _____ GROUP #: _____
POLICY HOLDER'S EMPLOYER: _____ POLICY HOLDER'S EMPLOYER: _____

IF PATIENT IS 18 YEARS OLD OR YOUNGER, PLEASE COMPLETE THE FOLLOWING INFORMATION

MOTHER'S NAME: _____ **CONTACT #**: _____

FATHER'S NAME: _____ **CONTACT #**: _____

_____ _____
PATIENT SIGNATURE (IF 18 OR OLDER) **DATE**

_____ _____

PARENT/RESPONSIBLE PARTY SIGNATURE (IF UNDER 18) RELATIONSHIP **DATE**

PATIENT NAME: _____ **DOB**: _____

INJURED BODY PART: _____ ☐ LEFT ☐ RIGHT

ARE YOU CURRENTLY UNDER PAIN MANAGEMENT?: ☐ NO ☐ YES _____
PAIN MANAGEMENT DOCTOR

PRIMARY CARE PHYSICIAN: _____

PHARMACY: _____ **PHONE #**: _____

CURRENT REVIEW OF SYSTEMS:

GENERAL:
WEIGHT CHANGE ☐ YES ☐ NO
FEVER OR CHILLS ☐ YES ☐ NO
TIREDNESS ☐ YES ☐ NO
☐ NO
NIGHT SWEATS ☐ YES ☐ NO
WEAKNESS ☐ YES ☐ NO
LUMPS/MASSES ☐ YES ☐ NO
DIZZINESS ☐ YES ☐ NO
CANCER ☐ YES ☐ NO
TYPE _____

URINARY:
INCONTINENCE ☐ YES ☐ NO
UTI'S ☐ YES ☐ NO
KIDNEY STONES ☐ YES ☐ NO
KIDNEY DISEASE ☐ YES ☐ NO

NEUROLOGIC/PSYCHOLOGICAL:
BLURRED VISION ☐ YES ☐ NO
STROKE ☐ YES ☐ NO
SEIZURES ☐ YES ☐ NO
DEPRESSION ☐ YES ☐ NO
BIPOLAR ☐ YES ☐ NO
ADD/ADHD ☐ YES ☐ NO
HEADACHES ☐ YES ☐ NO
DIZZINESS ☐ YES ☐ NO
PARALYSIS ☐ YES ☐ NO
LOSS OF BALANCE ☐ YES ☐ NO
LOSS OF FEELING ☐ YES ☐ NO

ENDOCRINE:
LUPUS ☐ YES ☐ NO
TREMULOUSNESS OF HANDS
☐ YES ☐ NO
INSULIN DEPENDENT DIABETES MELLITUS
☐ YES ☐ NO
NON-INSULIN DEPENDENT DIABETES MELLITUS
☐ YES ☐ NO

EARS/EYES/NOSE/THROAT
VISUAL CHANGE ☐ YES ☐ NO
BLEEDING GUMS ☐ YES ☐ NO

GASTROINTESTINAL:
NAUSEA ☐ YES ☐ NO
VOMITING ☐ YES ☐ NO
HEARTBURN ☐ YES ☐ NO
ABDOMINAL PAIN ☐ YES ☐ NO
ULCER ☐ YES ☐ NO
HEPATITIS ☐ YES ☐ NO
DIFFICULTY SWALLOWING
☐ YES ☐ NO

SKIN:
ITCHING OR RASH ☐ YES ☐ NO

RESPIRATORY:
TUBERCULOSIS ☐ YES ☐ NO
COPD ☐ YES ☐ NO
SLEEP APNEA ☐ YES ☐ NO
ASTHMA ☐ YES ☐ NO
SHORTNESS OF BREATH
☐ YES ☐ NO

GENITO-REPRODUCTIVE:
TAKING HORMONES ☐ YES ☐ NO
STD ☐ YES ☐ NO
MENSTRUAL IRREGULARITIES
☐ YES ☐ NO

CARDIOVASCULAR:
SEEN HEART SPECIALIST? ☐ YES ☐ NO
CHEST PAIN OR TIGHTNESS ☐ YES ☐ NO
CONGESTIVE HEART FAILURE ☐ YES
HIGH BLOOD PRESSURE ☐ YES ☐ NO
IRREGULAR HEARTBEAT ☐ YES ☐ NO
HEART MURMUR ☐ YES ☐ NO
SWELLING OF LEGS/FEET ☐ YES ☐ NO
BLOOD CLOTS ☐ YES ☐ NO

MUSCULOSKELETAL:
MUSCLE PAIN ☐ YES ☐ NO
NECK PAIN ☐ YES ☐ NO
SHOULDER/ARM PAIN ☐ YES ☐ NO
BACK PAIN ☐ YES ☐ NO
PAIN DOWN LEGS ☐ YES ☐ NO
☐ LEFT ☐ RIGHT
PAINFUL JOINTS ☐ YES ☐ NO
SWELLING OF JOINT ☐ YES ☐ NO
REDNESS OF JOINT ☐ YES ☐ NO
STIFFNESS OF JOINT ☐ YES ☐ NO
DEFORMITIES OF JOINTS OR EXTREMITIES
☐ YES ☐ NO
RHEUMATOID ARTHRITIS ☐ YES ☐ NO
OSTEOARTHRITIS ☐ YES ☐ NO
GOUT ☐ YES ☐ NO

OTHER:
MRSA ☐ YES ☐ NO
LATEX ALLERGY ☐ YES ☐ NO

PATIENT NAME: _____ **DOB**: _____

MEDICAL HISTORY (current or past):

CARDIOVASCULAR DISEASE	☐ YES	☐ NO	LIVER DISEASE	☐ YES	☐ NO
HEART ATTACK	☐ YES	☐ NO	SEXUALLY TRANSMITTED DISEASE	☐ YES	☐ NO
GASTROINTESTINAL DISEASE	☐ YES	☐ NO	URINARY TRACT DISEASE	☐ YES	☐ NO
PULMONARY DISEASE	☐ YES	☐ NO	CANCER	☐ YES	☐ NO
NEUROLOGIC DISEASE	☐ YES	☐ NO	EARS, NOSE, THROAT DISEASE	☐ YES	☐ NO
HEMATOLOGIC DISORDER	☐ YES	☐ NO	BLOOD CLOTS	☐ YES	☐ NO
			PREGNANCIES/DELIVERIES	Preg.#_____ /Del.#_____	
DIABETES	☐ YES	☐ NO			

OTHER: PLEASE EXPLAIN: _____

_____

SURGICAL HISTORY:

TYPE OF SURGERY	YEAR	TYPE OF SURGERY	YEAR
_____		_____	
_____		_____	

CURRENT MEDICATIONS: **IF NO MEDICATIONS, PLEASE CHECK BOX** ☐

(PLEASE LIST ALL MEDICATIONS INCLUDING ASPIRIN AND SUPPLEMENTS. IF MEDICATIONS EXCEED GIVEN SPACE, PLEASE ATTACH LIST.)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY
_____			_____		
_____			_____		
_____			_____		

DRUG ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES ☐ YES (LISTED BELOW)

_____

ALCOHOL: ☐ NEVER ☐ RARELY ☐ MODERATE ☐ DAILY

TOBACCO: ☐ NEVER ☐ PAST (YR. _____) ☐ CURRENT, OCCASIONALLY ☐ CURRENT, DAILY

ILLICIT DRUGS: ☐ NONE ☐ YES

FAMILY MEDICAL HISTORY: **IF NONE/ADOPTED, PLEASE CHECK BOX** ☐

RHEUMATOID ARTHRITIS	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
OSTEOPOROSIS	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
DIABETES	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
HIGH BLOOD PRESSURE	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
HEART DISEASE	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
STROKE	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
CANCER: TYPE _____	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER
OTHER _____	☐ FATHER	☐ MOTHER	☐ BROTHER	☐ SISTER	☐ SON/DAUGHTER

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

☐ Information is not to be released to anyone without further authorization.

☐ I authorize the release of my medical information by Orthopedic Solutions, including diagnoses, records, test results, exams, and reports to the individuals listed below.

☐ I authorize the release of my billing/financial information by Orthopedic Solutions to the individuals listed below.

☐ I authorize the release of both my complete medical and billing/financial information by Orthopedic Solutions to the individuals listed below.

Valid From: _____/_____/_____ to _____/_____/_____
TODAY'S DATE FUTURE DATE

(Examples of individuals listed below may include non-treating physicians, trainers, coaches, parents, guardians, or spouses.)

NAME: _____ RELATIONSHIP TO PATIENT: _____

METHOD OF RELEASE: ☐ FAX _____ ☐ PHONE _____ ☐ PICK UP
☐ MAIL _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

METHOD OF RELEASE: ☐ FAX _____ ☐ PHONE _____ ☐ PICK UP
☐ MAIL _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

METHOD OF RELEASE: ☐ FAX _____ ☐ PHONE _____ ☐ PICK UP
☐ MAIL _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED AND PURPOSE: I authorize the practice to disclose the patient's protected health information specified above to the individual(s) designated above at my request. I understand that this will result in the disclosure of the patient's confidential information.

EXPIRATIONS OR TERMINATION OF AUTHORIZATION: Unless terminated by the patient, the patient's personal representative or another individual(s) legally authorized to do so by court order or law, this authorization will remain in effect for one (1) year.

RIGHT TO REVOKE OR TERMINATE: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager, but such revocation will will not have any effect on disclosures made prior to receipt of the revocation. Revocation can be done in-person or by mailing a request to: Orthopedic Solutions, 101 S. Saints Blvd., Suite 101, Edmond, Oklahoma 73034.

REDISCLOSURE: I understand that the information to be released may be subject to redisclosure by the recipient and no longer protected by federal or state laws.

VOLUNTARY AUTHORIZATION: I understand that this authorization is voluntary. I may refuse to sign this authorization and the patient's treatment and/or payment obligations will not be affected unless (1) the treatment is related to research and the disclosure is related to such research; (2) the treatment is solely for the purpose of creating health information for disclosure to a third-party.

REMUNERATION: I understand that Orthopedic Solutions will not receive financial or in-kind compensation or remuneration in exchange for the disclosure of the patient's health information unless an applicable legal exception exists.

Orthopedic Solutions, PLLC complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

PATIENT SIGNATURE (IF 18 OR OLDER) DATE

PARENT/RESPONSIBLE PARTY SIGNATURE (IF UNDER 18) RELATIONSHIP DATE

AUTHORIZATION FOR MEDICAL TREATMENT: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Orthopedic Solutions. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

INFORMATION PRIVACY: Orthopedic Solutions will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information and has refused to retain a copy.

RELEASE OF INFORMATION: Orthopedic Solutions is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopedic technicians and/or coaches. I agree that Orthopedic Solutions may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I also authorize Orthopedic Solutions to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Orthopedic Solutions for application on the patient's bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

FINANCIAL AGREEMENT: 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 precertification 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 carrier, 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 Card, American Express, or MasterCard. We do have payment plans for patients who have financial concerns. Please notify our billing office at (405) 705-3191 to make payments or set up payment plans. Please be aware that charges for physical therapy, durable medical equipment (DME), 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. You will be responsible for all charges incurred at time of service, in accordance to our Self-Pay Policy.

Self-Pay charges are due at time of service. Charges will be incurred at a rate of 100% for the first visit and 50% for the following visits.

There is a $25 charge for any FMLA, disability, or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits, either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible in paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

PATIENT SIGNATURE (IF 18 OR OLDER) DATE

PARENT/RESPONSIBLE PARTY SIGNATURE (IF UNDER 18)	RELATIONSHIP	DATE