

# WELCOME TO OKLAHOMA SHOULDER CENTER, PLLC

PATIENT INFORMATION	
RECORD # _____	DATE: _____
PATIENT NAME: _____	
ADDRESS: _____	
CITY _____	STATE _____ ZIP _____
EMAIL _____	
<b>CONSENT TO EMAIL</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
AGE: _____	DATE OF BIRTH: ____/____/____
<input type="checkbox"/> LEFT HANDED <input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	
PATIENT SS#: _____	
OCCUPATION: _____	
EMPLOYER: _____	
EMPLOYER ADDRESS: _____	
EMPLOYER PPHONE: _____	
SPOUCSE'S NAME: _____	SPOUCE # _____
<b>TRICARE ONLY:</b>	
IS THIS A LOD INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
RACE <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> CAUCASION <input type="checkbox"/> OTHER _____	
ETHNICITY <input type="checkbox"/> FILIPINO <input type="checkbox"/> HISPANIIC/LATINO <input type="checkbox"/> NOT HISPANIC/NOT LATINO	
LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____	
WHOM MAY WE THINK FOR REFERRING YOU	
DOCTOR: _____	
ADDRESS: _____	PHONE: _____
PHONE INFORMATION	
CELL# (    ) _____	NOME: (    ) _____
WORK# (    ) _____	ext. _____
<b>IN CASE OF AN EMERGENCY:</b>	
NAME: _____	
RELATIONSHIP: _____	
CELL# (    ) _____	HOME: (    ) _____
WORK# (    ) _____	ext. _____
WERE YOU INJURED AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WERE YOU INJURED IN AN AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>IF YES TO EITHER QUESTION, PLEASE COMPLETE THE INFORMATION BELOW:</b>	
DATE OF INJURY _____	ADJUSTER NAME: _____
ADJUSTER PHONE NUMBER: _____	
CASE MANAGER NAME: _____	
CASE MANAGER PHONE NUMBER: _____	
STATUS OF CLAIM <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED	

INSURANCE INFORMATION	
<b>PRIMARY INSURANCE CARRIER:</b> _____	
<b>PRIMARY POLICY HOLDER:</b> _____	
<b>PRIMARY POLICY HOLDER DOB:</b> ____/____/____	
POLICY ID: _____	
POLICY GROUP #: _____	
<b>SECONDARY INSURANCE CARRIER:</b> _____	
<b>SECONDARY POLICY HOLDER NAME:</b> _____	
<b>SECONDARY POLICY HOLDER DOB:</b> ____/____/____	
POLICY ID: _____	
POLICY GROUP #: _____	
AUTHROIZATION ASSIGNMENT AND RELEASE	
<p>THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO <b>DR. ELIZABETH NOLAN</b> ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I'M FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.</p>	
_____	____/____/____
<b>RESPONSIBLE PARTY SIGNATURE</b>	<b>DATE</b>
MEDICARE PATIENT AUTHROIZATION ASSIGNMENT AND RELEASE	
<p>I REQUEST THAT PAYMENT OF COVERED MEDICARE BENEFITS BE MADE ON MY BEHALF TO <b>DR. ELIZABETH NOLAN</b> FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AUTHRORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMAIN THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. IF OTHER HEALTH INSURANCE IS INDICATED, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. THIS PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE, AND NONCOVERED SERVICES BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.</p>	
_____	____/____/____
<b>MEDICARE PATIENT SIGNATURE</b>	<b>DATE</b>

# OKLAHOMA SHOULDER CENTER, PLLC

If you have **Medicare Part A** please provide us with a copy of your card incase surgery is needed.

Thank You!

# OKLAHOMA SHOULDER CENTER, PLLC

HEALTH HISTORY  
(CONFIDENTIAL)

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_/\_\_\_/\_\_\_

AGE \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ DATE OF LAST PHYSICAL EXAM: \_\_\_/\_\_\_/\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ PRIMARY CARE DOCTOR PHONE: \_\_\_\_\_

WHAT IS YOUR REASON FOR THIS VISIT? \_\_\_\_\_

## SYMPTOMS ( Check the symptoms you currently have or have had in the past year.)

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE/EAR/NOSE/THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision-Flashes	<p style="text-align: center;"><b>ALL PATIENTS</b></p> <p style="text-align: center;"><b>DO YOU HAVE YOUR MEDICAL MARIJUANA LICENSE?</b></p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: center;"><b>DO YOU SMOKE?</b></p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> No</p> <p style="text-align: center;"><b>WOMEN ONLY</b></p> <p style="text-align: center;"><b>ARE YOU PREGNANT? _____</b></p> <p style="text-align: center;"><b>DUE DATE: _____</b></p>
<p><b>MUSCLE/JOINT/BONE PAIN, WEAKNESS, NUMBNESS</b></p> <p style="text-align: center;">IN:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling in ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal	
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			

## CONDITIONS ( Check the conditions you have or have had in the past.)

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Non Prescription Drugs	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> Herbal Supplements	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Thyroid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Diseases
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MEDICATIONS ( List medications you are currently taking.)	ALLERGIES (to medications or substances)	
	MEDICATION	REACTION

PHARMACY NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_





Oklahoma Shoulder Center PLLC  
Betsy M. Nolan MD  
725 NW 11<sup>th</sup> St  
Oklahoma City, OK 73103  
Ph: 405-278-8006  
Fx: 405-290-7388  
www.okshoulder.com

### Consent for Treatment and Financial Responsibility Oklahoma Shoulder Center, PLLC

As a patient of Oklahoma Shoulder Center, I authorize the physicians to examine, diagnose and render all treatment as they deem necessary. If care is needed for my minor / disabled child or relative custodial to me, I authorize the same treatment for them also.

I have requested that Oklahoma Shoulder Center bill my Insurance company for covered services provided by the physicians here on my behalf. I authorize payment directly to them. I understand that it is still my responsibility to make sure that the bill is paid in a reasonable time. If, for any reason, any portion of my bill is not paid by my Insurance, I further agree to make arrangements for prompt payment of the bill.

I understand that I am financially responsible for all charges not covered by this assignment.

I further understand that it is my responsibility to obtain referrals from my PCP if I have an HMO plan prior to my visits and agree to pay in full for the office visit, in the event this is not obtained prior to my seeing the physician.

I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

In order to process a claim for benefits, I authorize the physicians and their representatives at Oklahoma Shoulder Center to release to my Insurance company any information regarding my medical history, treatment, symptom, examination results or diagnosis necessary for payment of the claim. If this is a workers compensation claim, I authorize release of information to this carrier also, whether written or oral, for payment of this claim.

If I am not insured, I assume full responsibility for all charges for services rendered and agree to pay in full at the time of visit. I understand that it is not the policy of Oklahoma Shoulder Center to bill me for services. Payment is due in full when services are rendered.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: \_\_\_\_\_

MEDICAL RECORD #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

I hereby authorize: OKLAHOMA SHOULDER CENTER, PLLC

Name of Person/ Organization Disclosing PHI

To release the following information to: \_\_\_\_\_

Name and address of Person/Organization receiving PHI

**Information to be shared:**

- Psychotherapy Notes (if checking this box, no other boxes may be checked)
- Entire Medical Record
- Billing Information for \_\_\_\_\_
- Substance Abuse Records
- Mental Health Records
- Medical information compiled between \_\_\_\_\_ and \_\_\_\_\_
  - Other: \_\_\_\_\_

**The Information may be disclosed for the following purpose(s) only:**

- Insurance       Continued Treatment       Legal       At my or my representative's request
- Other: \_\_\_\_\_

**I understand that by voluntarily signing this authorization:**

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HI or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Legal Representative's Authority

\_\_\_\_\_  
Expiration date (if longer than one year from date of signature or no event is indicated)



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## Notice of Privacy Practices Medical

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPM" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we any use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** mean providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverages, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including the those related to disclosures to family member's, other relatives, close personal friends or any other person

identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we *must* abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 13, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate you for filing a complaint.

Please contact us for more information.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775





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## Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to.

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have received and read your Notice of Privacy Practices containing a *more* complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

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**Patient Name**

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**Relationship to Patient**

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**Signature**

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**Date**

## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute including but not limited to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by Oklahoma law, and not by a lawsuit or resort to court process except as Oklahoma law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother. The term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partner, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including council fees or witness fee, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties' consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of Oklahoma law applicable to health care provider shall apply to disputes within this arbitration agreement. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance

with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof I received, the claim, if asserted in a civil action, would be barred by the applicable Oklahoma statute of limitation, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Oklahoma laws relating to arbitration.

Article 5: **Intent:** It is the intent of this agreement to apply to all medical services rendered any time for any condition. This agreement is effective as of the date of the first medical services provided.

Article 6: **Severability:** If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement upon requesting one. By my signature below, I acknowledge that I have received or have waived receipt of a copy

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE IN DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: \_\_\_\_\_  
Patient's or Representative's Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Printed Name

By: Oklahoma Shoulder Center, PLLC  
(Typed company name and date is to act as signature of practice for this document only.)

Dated: 01/01/2016

**A signed copy of this document is to be given to Patient upon request. Original is to be filed in Patient's medical records.**

## **Pain Management Policy**

The appropriate management of chronic pain should rely primarily on non-opioid therapies and should incorporate a multi-model treatment plan to obtain the best outcome for the patient. As per Oklahoma state laws established in 2018, treatment of acute pain, such as normal anticipated pain after surgery is limited to a 7day prescription for narcotic medications with only one refill allowed, and no longer allowed after 2 weeks.

Given these restrictions and lack of lab and other infrastructure, it is the policy of this practice that no narcotic medication can be prescribed after the 2 week post-operative period.

Your signature affirms that you have read and agree to abide by this policy. Any pain requiring narcotic medication past the 2 week acute pain window, as defined by Oklahoma law, is considered chronic pain management. This office does not provide chronic pain management.

**Patient's Signature:** \_\_\_\_\_

**Patient's Printed Name:** \_\_\_\_\_





