

WELCOME TO  
*Oklahoma Shoulder Center, PLLC*

**Patient Information**

Date \_\_\_\_\_

Patient \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_  
 Sex:  M  F Age \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Are You:  Left-Handed  Right-Handed  
 Single  Married  Widowed  Separated  Divorced  
 Patient SS# \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 Employer Phone \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_  
 Birth date \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Race:  White  African American  
 Caucasian  Other \_\_\_\_\_  
 Ethnicity:  Filipino  Hispanic/Latino  
 Not Hispanic/Not Latino  
 Language:  English  Spanish  Arabic  
 Albanian  Other \_\_\_\_\_  
 Whom may we thank for referring you? Dr. \_\_\_\_\_  
 Phone# \_\_\_\_\_ Address \_\_\_\_\_  
 Pt. refused

**Phone Information**

Home Number: \_\_\_\_\_  
 Work Number: \_\_\_\_\_ Ext. \_\_\_\_\_  
 Best time to reach you: \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_

**Job or Related Insurance Information**

Were you injured at work?  Yes  No  
 If yes, name of Comp Carrier \_\_\_\_\_  
 Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Phone# \_\_\_\_\_  
 Were you injured in an auto accident?  Yes  No  
 Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Agent Name \_\_\_\_\_ Phone# \_\_\_\_\_  
 Claim Number \_\_\_\_\_

**Insurance Information**

Name of **Primary** Insurance \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Policy Holder Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Contract or Policy Number \_\_\_\_\_  
 Group Number \_\_\_\_\_ Service Codes \_\_\_\_\_  
 Name of **Secondary** Insurance \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Policy Holder Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Contract or Policy Number \_\_\_\_\_  
 Group Number \_\_\_\_\_ Service Codes \_\_\_\_\_

**Authorizations**

**Assignment & Release**

The undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am 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.

\_\_\_\_\_  
 Responsible Party Signature

\_\_\_\_\_  
 Relationship \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Authorization**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. \_\_\_\_\_ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier 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. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
 Signature/Relationship \_\_\_\_\_ Date \_\_\_\_\_



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.

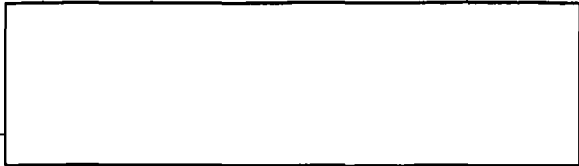
I further understand that it is my responsibility to obtain referrals from my PCP If I have an HMO plan prior to my visits and agree to pay in full for the office visit, in the event this is not obtained prior to my seeing the physician.

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, symptoms, 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.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_



**HEALTH HISTORY**  
(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last physical examination \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your reason for this visit? \_\_\_\_\_

**Symptoms (Check the symptoms you currently have or have had in the past year.)**

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	ALL PATIENTS
<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	<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	<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"/> Ear discharge <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 <input type="checkbox"/> Vision - Halos	Height _____ Weight _____ Blood Pressure _____ Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>MUSCLE/JOINT/BONE</b> Pain, weakness, numbness in: <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	<b>CARDIOVASCULAR</b> <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 of ankles <input type="checkbox"/> Varicose veins	<b>SKIN</b> <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	<b>WOMEN ONLY</b> Are you pregnant? _____ Due Date _____

**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 Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<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"/> 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"/> Typhoid 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)**


*(All information is strictly confidential)*

Family History (Fill in the health information about your family.)						
Relation	Age	State of Health	Age at Death	Cause of Death	Check box, if your blood relatives had any of the following: Disease: Relationship to you:	
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease, Strokes	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Other	

Hospitalizations		
Year	Hospital	Reason for Hospitalization and Outcome

List all of your doctors:	Address	Phone

**Have you ever had a blood transfusion?**  Yes  No  
 If yes, please give the approximate dates: \_\_\_\_\_

Serious Illness/Injury	Date	Outcome

Health Habits Check which substances you use and describe how much you use.	Occupational Concerns Check box if your work exposes you to the following:
<input type="checkbox"/> Caffeine	<input type="checkbox"/> Stress
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Hazardous Substances
<input type="checkbox"/> Drugs	<input type="checkbox"/> Heavy Lifting
<input type="checkbox"/> Other	<input type="checkbox"/> Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Oklahoma Shoulder Center, PLLC

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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, on 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. "HIPAA" 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 may 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** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, 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 references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives 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 your 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 those related to disclosures to family members, 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 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 against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA  
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

# Oklahoma Shoulder Center, PLLC

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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 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 Privacy 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.

Patient Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

## **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 partners, 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 counsel fees or witness fees, 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 providers shall apply to disputes within this arbitration agreement. Any party may bring before the arbitrations 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 is received, the claim, if asserted in a civil action, would be



