ALL SECTIONS MUST BE COMPLETED

Date: _____ Patient Account#: _____

PATIENT INFORMATION

Is this job related? ☐ Yes ☐ No

☐ Long-Term Facility ☐ Skilled Nursing Facility ☐ Hospice (Specify) _____

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Middle Initial)

Mailing Address: _____ SS#: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: _____ Work Phone: _____ ☐ Student ☐ Full Time ☐ Part Time

Cell Phone: _____ E-mail: _____ ☐ Employed ☐ Unemployed ☐ Retired

Language Preference: _____

Race: ☐ African-American/Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other or Undetermined

Employer: _____ Address: _____

REASON for this visit: _____ Date of first symptoms/injury: _____

Is this? ☐ Home ☐ Job Related ☐ Auto Accident ☐ Sports ☐ Liability ☐ Other _____

Is an Attorney involved? ☐ Yes ☐ No If Yes, Attorney's Name and Phone: _____

Where and how were you injured? _____

Were x-rays taken? ☐ Yes ☐ No Where? _____ When? _____ X-rays with you? ☐ Yes ☐ No

Referring Physician: _____ Family Physician: _____ ☐ Disk ☐ Film

EMERGENCY CONTACTS

Emergency Contact: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE POLICY HOLDER INFORMATION

Co-Pay $_____ Deductible $_____ THIS SECTION MUST BE COMPLETED

PRIMARY COMPANY: _____

Address: _____

City, State: _____ Zip: _____

ID#: _____ Group#: _____

Subscribers Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City, State: _____ Zip: _____

Employer: _____

SECONDARY COMPANY: _____

Address: _____

City, State: _____ Zip: _____

ID#: _____ Group#: _____

Subscribers Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City, State: _____ Zip: _____

Employer: _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Responsible Party: _____ Responsible Party Date of Birth: _____

Address: _____

Relationship to patient: _____ SS#: _____ Home Phone: _____

Responsible Party Employer: _____ Work Phone: _____

I request that payment of authorized benefits be made to **Southern Oklahoma Multiple Services,** on my behalf for any services provided to me or my dependents. I authorize the release of any medical information to any insurance company, any third party payer, state agency, employer, or any other governmental or private payer responsible for paying such benefits. I agree to pay for all charges not covered by a third party payer. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself or my dependents. I authorize a copy of this document to be used in place of the original.

Signature of Patient/Insured: _____ Date: _____

Bone & Joint Clinic of Southern Oklahoma

Patient _____ Account # _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as part of my health and medical care, the Bone and Joint Clinic of Southern Oklahoma originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

+ a basis for planning my care and treatment

+ a means of communication among the health professionals who contribute to my care

+ a source of information for applying my diagnosis and treatment information to my bill

+ a means for a third-party payer to verify that services were billed as actually provided

+ and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that the Bone and Joint Clinic of Southern Oklahoma reserves the right to change their notice and practices, but that prior to implementation a copy of any revised notice will be posted at the Bone & Joint Clinic of Southern Oklahoma. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Bone and Joint Clinic of Southern Oklahoma is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you ..... **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

In addition to the releases outlined above, information and prescriptions may only be released to the following individuals/organizations for the indicated purpose:

PLEASE PRINT

_____ _____

_____ _____

I request the following restrictions to the use and/or disclosure of my health information**:** _____

_____

By signing this form, I agree that the Bone & Joint Clinic of Southern Oklahoma may leave appointment reminders or medical information messages via phone, email, and fax information as appropriate for me with the information I have provided. Additionally, I give permission to request my prescription history. If permission is not given, I understand that I may be redirected for pain medication. In addition, I give permission to the Bone & Joint Clinic of Southern Oklahoma to contact me via current and any future cellular phone numbers, email addresses, or wireless devices regarding my delinquent accounts I owe to Bone & Joint Clinic of Southern Oklahoma. I authorize its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

_____ _____

Signature of Patient or Legal Representative Date Notice Effective

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The Bone and Joint Clinic of Southern Oklahoma accepts conditionally the restrictions imposed on release of information as stated above.

_____ _____

Signature / Title Date

#HIPAA

ACCOUNT# _____

PATIENT MEDICATION LIST

PATIENT NAME: _____ DATE: _____

PHARMACY PREFERENCE: _____

Please list all prescriptions, supplements, and over-the-counter medications you are currently taking

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

#MedicationList

Bone & Joint Clinic of Southern Oklahoma

POLICIES

Welcome to The Bone and Joint Clinic

Whether you have a long history with orthopedic issues or this is your first encounter with it, we hope that your experience in our office helps you on the path towards better health.

Commitment to Patient Care

Policies are necessary for any office to run effectively; however, it's important to keep in mind the goals of the office. We are here to help people change in positive ways. To be committed to positive change means openness, collaboration, and personal responsibility. Ultimately, your health is your responsibility; our job is to facilitate your path to wellness.

Appointment Reminders

An appointment card is given to each patient at the time their return appointment is scheduled. In addition, as a courtesy, this office reminds you of your upcoming appointment. Our method of choice is email, so we ask that you provide us with your email address. **Important - Please Note:** No phone calls will be made if an email address is provided. If you do not have an email, we will remind you via phone.

Financial Responsibility

Office Visit: Charges are based on type of visit and any other procedure performed. Copays, deductibles, and balances are due at check in. If unable to pay, your appointment will be rescheduled, giving you an opportunity to meet financial requirements. We offer Care Credit, if applicable, to assist you with the required deposit. Self pay patients require a $300 deposit.
Cancellation of Appointment: When you schedule an appointment, we reserve that block of time for you. If unable to keep your appointment, we ask that you call and cancel no later than 24 hours in advance. A no-show fee is charged to patients who do not call and cancel. Rates are as follows: $25 for Follow-Up Appointments, $50 for New/Return New Appointments.
Surgery Deposit: We collect surgery deposits on surgeries. The deposit is due prior to the surgery date. If deposit is not paid, surgery will be rescheduled or cancelled. The deposit is collected for deductibles not met at the time surgery is scheduled. We offer Care Credit, if applicable, to assist you with the required payment.
Returned Checks: We assess a $25 fee plus the amount of the check for any returned check.
Forms: We assess a $10 fee for forms that require completion by our office, FMLA, Short Term Disability, AFLAC, etc.

Medication Refills

If you need a medication refill, please call 223-4795 option 2. Refill requests will be addressed by the end of the day. Requests received after 3p.m. will be addressed the following business day. Please allow 24 hours for prescriptions to be approved. Narcotic prescriptions, by law, are not able to be called in. You must pick up a written prescription. Only the persons listed on your HIPPA will be allowed to pick them up for you.

Medical Services

Fracture Care: We are required by the American Medical Association (AMA) to use fracture codes when billing for a fracture which are listed under the Surgery Category in the AMA CPT Code Book. These show as a "surgery" on your EOB (Explanation of Benefits) from the insurance company. This does not mean you had a surgery. It is simply categorized that way. You will have a "Global Period" of 90 days in which you will not be charged acopay, which does not include x-rays, cast applications or supplies, etc. We only bill for our physician's services; not the hospital, surgery center, radiologist, anesthesiologist or other facility.
DonJoy Bracing: If you receive a brace, sling, splint, or corset in our office, you are billed directly by Agility Medical and not our office. You are given a copy of the Agility receipt which has information and phone numbers if you have questions.
Injections: Injection codes are also listed under the Surgery Category by the AMA. This does not mean you had a surgery. Once again, it is simply categorized that way.
Surgery: You will have a "Global Period" of 10-90 days, depending on the type of surgery, in which you will not be charged a copay. This does not include x-rays, cast applications or supplies, etc. We only bill for our physician's services; not the hospital, surgery center, anesthesiology, labs, MRIs, radiology or other facility.

Thank you for allowing us to provide our medical services to you. Please know that our patients are important to us.