OSSO
AN HPI AFFILIATE

North Office: 1616 S Kelly Ave, Edmond, OK 73013 South Office: 3115 SW 89th St, Oklahoma City, OK 73159 Phone:405.486.6820 Fax: 405.426.6443

How did you hear about our practice?	Adjustor/Case Manager	Please list referral name:

PATIENT INFORMATION

(Please 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 ◯ Full-time student ◯ Part-time 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
Insured Employer	Phone Number

If the patient is a minor, please list both parent names and employers

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:

THIRD PARTY BILLING (choose one)

Is your injury work related?	◯	YES ◯ NO
Is this 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:

OKC SPINE & ORTHOPEDIC
www.okcspineortho.com

Charles A. Hogan, MD
Reconstructive Spinal Surgery

North office:
1616 S Kelly Ave
Edmond, OK 73013

South office:
3115 SW 89th St
Oklahoma City, OK 73159

Phone:
405-486-6820

Fax:
405-426-6443

www.okcspineortho.com

Dear Valued Patient,

Welcome to our practice. In order to facilitate your care, the following office policies have been created. Please read them carefully and ask us to clarify any questions you might have.

1. Dr. Hogan is trained as a spine surgeon. He is is not trained in pain management. As such, he does not and will not prescribe medications for the treatment of chronic spinal pain. Ample pain medicine is provided in the hospital for surgical conditions and for an appropriate duration thereafter. Patients with pain management issues will be referred to their primary care doctor or to a neuropsychiatrist with a special expertise in management of chronic pain.

2. Please see attached addendum for details regarding pain management and medication refills. Recent changes have been made at the state level regarding narcotic prescriptions.

3. We respect the value of your time and will make every effort to remain on schedule. Occasionally, emergencies cause us to be late or necessitate that we reschedule your appointment. In that event, we will make all attempts to contact you before you reach our office. Out of respect for other patients, if you need to cancel, we ask that you call with as much advance notice as possible so we may give your appointment away. A cancellation fee or appointment no show fee of $35 will apply with less than 24 hours notice given, not billable to insurance.

4. Please do not call the office for test results. Diseases of the spine and the tests to evaluate them are highly complex and Dr. Hogan prefers to review all test results directly with the patient. Please make an appointment no less than 10 days following your test to discuss the results with Dr. Hogan. **If you have an imaging study (x-ray, CT scan, MRI, EMG nerve test, DEXA bone density scan) done at an outside facility, please obtain a CD of the images AND the radiologist report and bring them to your next appointment. DO NOT RELY ON THE IMAGING FACILITY TO "MAIL US THE FILMS".** If imaging is done at Community Hospital or Lakepointe Imaging, we will already have access to the imaging and reports.

5. Disability forms are time consuming for our staff and cannot be completed during clinic hours. Please allow 10 days for completion of such forms. Be sure to complete your portion of the form prior to leaving it with us and provide a self-addressed, stamped envelope. Although we are happy to fill out forms for our patients, the time demands placed on our staff associated with such forms are significant. As a result, we must charge a $35 fee for each form. We regret any inconvenience this may cause.

6. If you have accounting or billing inquiries, please ask for the insurance department when you reach our operator or call (405) 419-8444.

Please sign below to indicate that you received and fully understand these policies.

_____ _____

Signature Date

North Office: 1616 S Kelly Ave, Edmond, OK 73013 South Office: 3115 SW 89th St, Oklahoma City, OK 73159 Phone:405.486.6820 Fax: 405.426.6443

Chart No. _____

OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

Authorization to Release Information via Phone/Family/Friends

Patient Name:_____ DOB:_____

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 voicemail or with the individual who answers the phone at any of the below numbers. I authorize the staff to send and receive email regarding my care to the email address listed below.

Home Phone _____ Work Phone _____
Cell Phone _____ Other _____
Email _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plans, 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 that this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

OSSO STAFF ONLY

Documented by: Initials _____ Date _____

North Office: 1616 S Kelly Ave, Edmond, OK 73013 South Office: 3115 SW 89th St, Oklahoma City, OK 73159 Phone:405.486.6820 Fax: 405.426.6443

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 or advisable 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 VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Sports Science and 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 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 and jewelry.

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

SIGNED _____ DATE _____
(Patient)

OR _____
(Nearest relative or responsible party)

_____ Policyholder's Signature _____
(Relationship to patient)

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 healthcare 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 Dept. of Health, or by law.

North Office: 1616 S Kelly Ave, Edmond, OK 73013 South Office: 3115 SW 89th St, Oklahoma City, OK 73159 Phone:405.486.6820 Fax: 405.426.6443

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

A DIVISION OF THE PHYSICIANS' GROUP

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopaedics (OSSO) as your healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care.

In addition to accepting traditional insurance plans and Medicare we are contracted with numbers of 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 pre-certification 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 company 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, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.486.6820 to make financial arrangements. Please be aware that charge for physical therapy, durable medical equipment, 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 (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. **Please note that Dr. Hogan does not accept third party/MVA patients. Please also note that Dr. Hogan does not accept workman's compensation patients.**

There is a $35 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Oklahoma Sports Science & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed_____ Date_____
(signature of person financially responsible for payment)

Relationship if other than patient_____

OSSO
AN HPI AFFILIATE
North Office: 1616 S Kelly Ave, Edmond, OK 73013 South Office: 3115 SW 89th St, Oklahoma City, OK 73159 Phone:405.486.6820 Fax: 405.426.6443

DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Charles Hogan has an ownership interest in Community Hospital and Northwest Surgical Hospital.
2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.
3. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visits our website(s), communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____
Signature of Patient

_____
Signature of Parent/Guardian
(if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian

_____
Date

CHARLES HOGAN M.D.

AGREEMENT AND INFORMED CONSENT FOR NARCOTIC PRESCRIPTIONS & CHRONIC PAIN

Print Patient Name: _____ DOB: _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient may be taking for pain management. This is to help both the patient and their provider comply with the law regarding post-surgery pain management. Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.

The use of opioids may cause addiction and is only one part of a complete treatment plan.

I agree to the following:

1. I may be prescribed an opioid pain medication as part of my treatment plan to manage my chronic pain. The pain I am experiencing may be improved, but not eliminated, with the use of these opioid medications.
2. Opioids are a type of powerful pain medication often called narcotics. They can be very useful in managing pain, but they have a high potential for dependency and addiction.
3. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will store opioid medications in a secure location to prevent others from taking them and will safely dispose of them when I am no longer using them.
4. I will not take any medicine not prescribed to me.
5. Forging or altering a prescription or distributing medications to others is a crime. I understand that should any of the above occur, my care with this office will be terminated and I will be reported to law enforcement authorities.
6. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
7. I will not increase my medicine until I speak with my doctor or nurse.
8. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
9. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
10. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
11. I agree to come to the office for a pill count at any time if asked by my doctor.
12. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
13. I will inform my doctor about all other medicines I am taking. 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.
14. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit and again randomly through the course of my treatment.
15. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics and Dangerous Drugs Prescription Monitoring Program.
16. There are several risks of opioid medications that my treating physician has discussed with me. 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 my responsibility to inform my treating physician about all other medicines I am taking.
17. I should not drive an automobile or operate any machinery when taking opioid medications.
18. I understand that opioid medications can adversely affect my judgment in making business decisions.
19. My treating physician has discussed with me alternative pain management approaches that may be available to manage my pain instead of taking opioid pain medications and the risks and benefits of the alternatives.
20. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control, and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.

21. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence that I am improving, or that progress is being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician or to a neuropsychiatrist with a special expertise in management of chronic pain.
22. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

Refills

- I understand that refills of opioid medication will be given only after I have been appropriately assessed by my healthcare provider. If the medication requires a written prescription, I must call 3 business days in advance.
- I understand that refills will be made only during regular office hours—Monday through Thursday, 8:00 AM-4:00 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 3 business days is required.
- I must keep track of my medications. No early or emergency refills may be made.
- Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before a new prescription will be written.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain opioids from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if opioids have been obtained from another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors, or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my 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: _____

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: _____ Date: _____