OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

Name: _____ Exam Date: _____

Age: _____ Occupation: _____ Dominant Hand: _____

CHIEF COMPLAINTS

Part (s) of the body injured: _____

HISTORY OF INJURY

Exact date of injury: _____ Day of week: _____

Employer at time of injury: _____

City and State where injury occurred: _____

What were you doing and how did your injury occur? (Please describe in detail): _____

_____

_____

Immediately following the injury what part(s) of your body hurt? _____

_____

Describe the pain and problems following the injury: _____

_____

Did you report the injury to your employer? YES / NO If yes, when: _____

When did you first receive medical treatment for the injury? (date): _____

Name of doctor, clinic, and/or hospital that treated you: _____

_____

Were X-Rays taken? _____ If yes, what part of the body? _____

Any physical therapy? _____ If therapy, where? _____

How often did you receive physical therapy? _____ How long? _____

Describe any other treatment given since the injury: (i.e. cast, surgery, TENS unit, etc) _____

_____

Did this help? _____ If yes, describe improvement: _____

_____

Have you seen any other doctors, clinics, hospitals since the injury? _____

Doctor	Specialty	Referred by	City	Date first seen

Details (special tests, dates of hospitalization, dates of surgery, etc.) _____

Any new injuries or re-injuries since the date of injury? _____

If yes, please describe and give dates: _____

Have you missed any time from work as a result of your injury? _____

If yes, when was the last day you worked? _____ Returned to work? _____

Were you ever told to return to modified duties? _____ If yes, when? _____

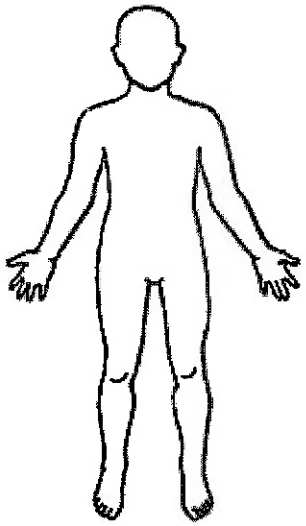
Are you currently working? _____ Same company? _____

PRESENT COMPLAINTS: (describe in detail)

Indicate with the following symbols what kind of pain and where it is located:

Sharp pain - xxxxx Dull pain - ooooo Numbness or tingling – use shading

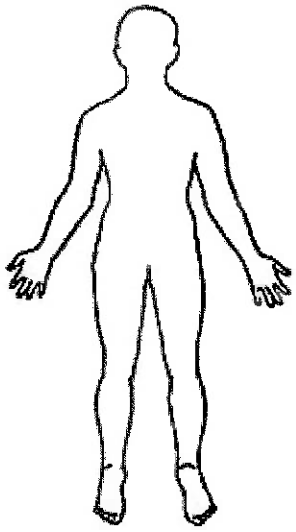
Right



Left

Front

Right



Left

Back

Does the pain travel? YES / NO

If yes, describe where it travels: _____

_____

What makes pain worse? _____

What makes pain better? _____

Where does it hurt the most? _____

Describe your pain: DULL SHARP ACHING STABBING THROBBING BURNING

Other: _____

On a scale of 1 to 10, 10 being the worse, Rate your pain 0 1 2 3 4 5 6 7 8 9 10

PRESENT TREATMENT:

Are you still treating with the first physician who saw you for your injury? _____

If no, name of current treating physician: _____

Type of treatment you are receiving: _____

Date of last visit with current treating physician: _____

Date of last treatment (i.e. injection, physical therapy, medication)_____

OCCUPATIONAL HISTORY

Job title	Employer	From (month/year) to (month/year)

JOB DESCRIPTION

When the injury occurred how many hours did you work in a day? _____ Week _____ Overtime_____

Occupation at time of injury: _____

List of job duties and physical requirements of your work at the time of injury: _____

_____

_____

_____

Work activities performed: Mark your usual work duties (at the time of injury) with the following letters:
N = Not at all O = Occasionally F = Frequently C = Constantly 3

_____ Stand
_____Walk
_____Climb
_____Squat
_____Lift

_____Kneel
_____Stoop
_____Push
_____Pull
_____Bend

_____Reach
_____Twist
_____Drive vehicle
_____Detailed hand work

_____Overhead work
_____a. 10lbs or less
_____b. 11 to 25 lbs
_____c. 26 to 50 lbs
_____d. 51 to 75 lbs
_____e. 76 to 100 lbs
_____f. over 100 lbs
_____ With assistance?

Total years performed this type of work? _____Total years worked for employer at time of injury? _____

Work activities performed on present occupation (if different than above) Mark your usual work duties with the following letters: N = Not at all O = Occasionally F = Frequently C = Constantly 3

_____ Stand
_____Walk
_____Climb
_____Squat
_____Lift

_____Kneel
_____Stoop
_____Push
_____Pull
_____Bend

_____Reach
_____Twist
_____Drive vehicle
_____Detailed hand work

_____Overhead work
_____a. 10lbs or less
_____b. 11 to 25 lbs
_____c. 26 to 50 lbs
_____d. 51 to 75 lbs
_____e. 76 to 100 lbs
_____f. over 100 lbs
_____ With assistance?

Other: _____Total number of years at this type of work: _____

PAST MEDICAL HISTORY

Have you had previous injuries or treatment to any parts of the body of which you are being seen for today? YES / NO

If yes, please give dates and types of treatment. Please include sports injuries or motor vehicle accident etc _____

_____

_____

_____

_____

Any other work related injuries not described above? _____

_____

Did you recover from above injuries? _____ if no, please explain: _____

_____

I certify that the above information is true and correct to the best of my knowledge. I understand it is important and necessary to give correct information for a proper medical evaluation.

_____ _____

Patient's Signature Date

Name:_____ DOB: _____MR#: _____

Age: _____Height: _____ Weight: _____

Primary Care Physician/ Referring Physician Name and Phone Number: _____

Have you ever seen a Cardiologist? YES / NO If yes, who: _____

Reason for Today's Visit: _____

Injury? YES / NO Date of Injury? _____ Work related? YES / NO Auto Accident? YES / NO

Brief Description of Injury: _____

MEDICATIONS List all medications you are currently taking: Prescription and over-the-counter medications (example: aspirin, antacids, sinus & allergy medications, etc)

☐ I AM CURRENTLY NOT TAKING ANY MEDICATIONS

Medication Name	Dosage	Frequency

PHARMACY List name and location of your preferred pharmacy to use when calling in prescriptions:
Pharmacy: _____ Location / Phone#:_____

ALLERGIES:

☐ I have no known allergies.

Other Allergies	**Describe Reaction** (e.g., hives, rash, itching, nausea, diarrhea, headaches, fainting, shortness of breath, shock, etc.)

Patient Signature _____ **Date** _____

OSSO

OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

Robert S. Unsell, M.D. 10001 S. Western, Ste 101 OKC, OK 73139 405-692-3700

PATIENT INFORMATION

(please fill in all blanks)

Patients Legal Name: Last	First	M.I.	Sex:	DOB:	Age:

Social Security Number:	Email Address: Declined ☐	Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single	Spouses Name:

Patients Address:	Employment Status: ☐ Employed ☐ Full-time student ☐ Part-time student ☐ Retired

City:	State:	Zip:	Referring Physician:

Home Phone:	Work Phone:	Cell Phone:	Preferred Language:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Race: ☐ White ☐ Asian ☐ Black ☐ Pacific ☐ Native American ☐ Multiple ☐ Other

INSURANCE INFORMATION – We will need a copy of the insurance card in order to file a claim.

Name of the Primary Insurance Company_____

Name of the person who carries the insurance policy_____Relationship to Patient_____

Carriers DOB _____ Carriers SS# _____

Carriers Employer_____

Seconday Insurance_____

Carriers DOB _____ Carriers SS# _____

Carriers Employer_____

EMPLOYMENT INFORMATION

N / A ☐ Patients Employer _____ Phone Number _____

N / A ☐ Insured Employer _____Phone Number_____

If Patient is a minor, please list both parents names and employers

N / A ☐ Mother _____ Employer_____ Phone #_____

Father _____ Employer_____ Phone# _____

NEXT-OF-KIN INFORMATION

Nearest Relative (or Friend, Not Spouse) Not living with you:

Home Phone: Relationship to patient:

WHO REFERRED YOU TO OUR OFFICE?

Adjuster Attorney Billboard Case Manager Doctor Employer Friend Hospital Insurance Company Magazine
Neighbor Phone Book Coach Physical Therapist School Trainer Radio Other

THIRD PARTY BILLING

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 hearby authorize my insurance benefits 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 informationin the processing of any insurance claims. I acknowledge that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

Chart No: _____

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

Authorization to Release Information via phone / Family /Friends

Patient Name: _____ DOB:_____

I hereby authorize confidential communications form 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:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, 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 this authorization will remain in effect for one year or unless I revoke the authorization in writing.

Patient Signature: _____ Date: _____

OSSO STAFF ONLY:
Documented by:

_____ _____
Initials Date

Oklahoma Sports Science & Orthopedics

FINANCIAL POLICY

Thank you for choosing Oklahoma Sport Science & Orthopedics as your healthcare provider. At OSSO we are dedicated to providing the highest quality, most cost effective care. We specialize in Adult and Pediatric Orthopedics, Sports Medicine, Physical Medicine and Rehabilitation, Pain Management, Reconstructive and Orthopedics Spine Surgery and Hand Surgery.

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 provider's 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 with all referral, pre-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 to each appointment your current insurance card or any other information that is required by your insurance carrier. 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. In most cases we can arrange payment plans for patients who have financial concerns. Please notify our office at 692-3700 to make payment arrangements. **Please be aware that charges 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, unless other arrangements have been made, you may be set up 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 a third party in order to ensure payment to the physician. **Please note that not all OSSO Physicians will accept third party/ MVA patients.**

There is a $40 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 any other invasive procedures that are scheduled at Community Hospital, Northwest Surgical Hospital or Community Hospital North, 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 and Orthopedics to participate in your care.

Sincerely,
OSSO Physicians and Staff

My signature below acknowledges receipts of this Financial Policy:

Signed: _____ Date: _____
(Signature of person financially responsible for payment)

Relationship if other than patient: _____

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopedics 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 & Orthopedics 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 & Orthopedics charge or who may be responsible in 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, 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 release all of the information in my medical records, including any information concerning identity, and release Oklahoma Sports Science & Orthopedics, its agents and 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 to Oklahoma Sports Science and Orthopedics. I understand that I am financially responsible for charges not covered by this assignment.

I 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 a balance owing for 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 and Orthopedics from any claim for responsibility or damages in the event of loss of my personal property, including, but not limited to, money and jewelry.

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

SIGNED _____ **DATE** _____
(PATIENT)

OR_____
(RESPONSIBLE PARTY OR NEAREST RELATIVE)

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 of exposures, release risk of exposures, release pursuant to an order of the court of the Department 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 the order of the court, or the department of health, or by law.

Robert Unsell, M.D.

- The pain you are experiencing may be improved, but not eliminated with use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be filled if you don't keep these appointments.
- Pain medication is filled only for post-operative patients and not filled indefinitely. If pain medications are needed beyond this period you will be referred to long term pain management.
- Your treating physician is the only physician who should prescribe narcotic pain medication to you.
- It is your responsibility to notify us of any other Physicians who are prescribing narcotic pain medications to you. It is also your responsibility to inform other physicians that we are prescribing you narcotic pain medications.
- Any "Drug Seeking Behavior" will not be tolerated and will result in your dismissal as a patient and possible reporting to the police, DEA, or FDA. Drug seeking behavior includes, but is not limited to: excessive calls requesting increase in the does or frequency of pain medication, refills before they are due, and doctor shopping. Dispensing your medication to others for their use or for money will result in the same consequences.
- Pain medication refill request are taken **Monday through Thursday from 8:30 a.m. to 3:30 p.m. only. Prescription refills are not taken or called in on Friday, Saturday, Sunday, holidays or after hours for any reason.** We guarantee prescription refills will be processed within 72 hours of the request.
- Lost, stolen or misplaced medications **are never replaced - no exceptions.** Your medication is your responsibility.
- Narcotic pain medication has many side effects. Overuse could lead to breathing difficulties and even death. Heavy machinery should never be used while taking pain medication. Make sure you are educated on the possible side effects of your medication by your pharmacist. If you have any concerns please contact our office.

Informed consent: I _____ have been informed and clearly understand the above-listed issues regarding the treatment of pain with narcotic pain medication. I understand that this agreement will be filed in my chart as part of my permanent medical record.

Signature _____ Date _____

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, this information is being provided to you to help you make an informed decision about your health care.

1. Dr Robert S. Unsell 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 health care 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 visit our website at 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 or Guardian
(if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian

Date:_____

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

SURGERY OPIOID CONSENT FORM

Patient Name:	**Date of Birth:**
The doctor may prescribe Opioids to control and manage post-surgical pain.	
Alternative options to opioids are Over the counter pain medications such as Tylenol, Advil, Excedrin.	

Instructions: *Please review the information listed below and put your initials next to each item when you feel you understand and accept what each statement says.*

	Initials
My surgeon will prescribe an opioid medication to help me control and manage post-surgical pain.	
This medicine is used to decrease and manage my pain but will not take away my pain completely.	
I will stop using the opioid medicine as soon as my pain is manageable and will use over the counter pain relievers if possible to manage the pain.	
I will contact my provider if the medicine does not control my pain when I take it as prescribed or if I have any adverse reactions to it.	
I will follow-up with my provider for post-surgical consultations as instructed or requested by my provider.	
If I do not use all of the medicine prescribed, I will ensure that it is disposed of properly in order to prevent its misuse by someone else.	
I will safely store the medicine to minimize the risk that children or other people will take it.	
When I take this medicine it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.	
When I take this medication, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.	
I may become physically or psychologically dependent or addicted to this medicine if I take them continuously so I agree to stop using them at the earliest possible time and to take no more than is necessary to control my pain.	
I have told my provider if I or anyone in my family has had any problems with mental illness or with controlling drug or alcohol use in the past.	
Taking too much of my pain medication, or mixing my pain medications with drugs, alcohol, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.	
It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.	
I will not use any illegal substance, such as cocaine, etc., while taking this medicine.	
If I travel out of the country while taking this medicine, I will notify the appropriate travel authority (usually the consulate website of the country) and obtain a note from my provider before travel, as traveling out of country with opioids may pose problems.	
For females: I understand it is my responsibility to inform my provider if I am pregnant.	

Signature of patient or guardian	**Date**
Printed name of patient or guardian:	