PATIENT INFORMATION

Name (Last, First, MI):					
Street Address:			City, State, Zip:		
Mailing Address:			City, State, Zip:		
Home Phone:		Cell Phone:		Male	Female
SSN:	Date of Birth:		Single	Married	Divorced	Widowed
Patient Race: 1. American Indian/Alaskan Native 2. Asian 3. African American 4. Caucasian 5. Other 6. Unknown					
Patient Ethnicity: 1. Hispanic Origin 2. Not of Hispanic Origin 3. Unknown			Religious Preference:		
Patient's Employer			Employer Phone:		
Employment: Full Time Part Time		If patient is retired, please give retirement date:			

RESPONSIBLE PARTY

Name (Last, First, MI):			
Street Address:		City, State, Zip:	
Mailing Address:		City, State, Zip:	
Home Phone:	Cell Phone:	Work Phone:	
SSN:	Relationship to the patient:		Date of Birth:
Employer Name:			
Employer phone:			

If your visit is due to an accident or injury please give the following information

Worker's Comp	Auto Accident	Personal Liability	Date of Injury:
Attorney Name and Phone Number:			

PRIMARY INSURANCE

Insurance Carrier:		Policy Holder SSN:
Policy Holder:	ID #	Phone:
Policy Holder Employer:		Group #
Relationship to the patient:		Policy Holder Date of Birth:

SECONDARY INSURANCE

Insurance Carrier:		Policy Holder SSN:
Policy Holder:	ID #	Phone:
Policy Holder Employer:		Group #
Relationship to the patient:		Policy Holder Date of Birth:

EMERGENCY CONTACT

Name:	Phone:
Relationship to the patient:	

OCOM IMAGING

An Affiliate of INTEGRIS Health

Safety Screening and Instruction Sheet

Yes	No	
☐	☐	Do you have a pacemaker?
☐	☐	Do you have an artificial heart valve?
☐	☐	Do you have any implanted electronic devices?
☐	☐	Do you have any blood vessel or brain aneurysm clips?
☐	☐	Have you ever had a joint replacement, surgical pins, or surgical staples implanted?
☐	☐	Do you have any ear implants such as cochlear implants, stapes implants, hearing aids, or metal tubes?
☐	☐	Have you ever had eye surgery?
☐	☐	Have you had any surgeries in the last three months?
☐	☐	Have you ever had a gunshot or shrapnel injury?
☐	☐	Have you ever done any welding, metal work, or been exposed to metal or metal dust in the eyes?
☐	☐	Do you have any tattoos or permanent make-up?
☐	☐	Do you have ear staples (diet)?
☐	☐	Do you have any metal inside your body of any type?

Please remove all hairpins.

Please remove all jewelry, including all piercings.

Please wear comfortable clothing with no metal, if possible.

____

Patient Signature (Parent or guardian if patient is a minor) **Date**

Place Patient Label Here

Revised 6/2011

Female Pregnancy Screening and Consent

Yes	No	
❐	❐	Are you pregnant?
❐	❐	Is there any possibility that you might be pregnant?
❐	❐	Are you breast feeding?
❐	❐	Have you had a hysterectomy? Date ___________
		Date of last menstrual cycle. ________________

_______________________________________ ______________

Patient's Signature (Parent or guardian if patient is a minor) Date

If I am pregnant, there is a possibility that I might be pregnant, or I am breast feeding, the contraindications and possible side effects have been explained to me by the Technologist or Nurse, and I fully understand.

I, hereby, give my consent to continue with the examination. I do not, and will not hold Oklahoma Center for Orthopaedic & Multi-Specialty Surgery liable in any way.

_______________________________________ ______________

Patient's Signature (Parent or guardian if patient is a minor) Date

_______________________________________ ______________

Technologist's Signature Date

Revised 3/15

Pregnancy Screening

Place Patient Sticker Here

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Consent for Intravenous Contrast Material Administration

Yes **NO**
[ ] [ ] Have you ever had contrast material (dye) injected into a vein?
[ ] [ ] If so, did you have an allergic reaction?
[ ] [ ] Do you suffer from renal (kidney) failure?
[ ] [ ] Are you on dialysis?
[ ] [ ] Do you have diabetes? How long?____________________
[ ] [ ] If so, do you take pills or shots for it?
[ ] [ ] Do you take Metformin (Glucophage, Glycon, Glucovance, Avandamet, or Metaglip)?
How long?____________________
[ ] [ ] Do you have heart disease?
[ ] [ ] Do you have liver disease?
[ ] [ ] Do you have Sickle Cell disease?
[ ] [ ] Do you have multiple myeloma?
[ ] [ ] Do you have pheochromocytoma?
[ ] [ ] Do you have myasthenia gravis?
[ ] [ ] Do you suffer from asthma?
[ ] [ ] Are you pregnant?
[ ] [ ] Are you breast feeding?

Please list any allergies and reactions to foods or medications: ____________________

____

____

[ ] **No Known allergies**

Risks

For certain diagnostic examinations, FDA-approved contrast material (dye) may be injected into a vein. Although rare, adverse reactions may occur. Reactions may be limited to the injection site an include redness, swelling, and pain, or be generalized and include shortness of breath, nausea, vomiting, chills, and hives. In more severe cases, irregular heart rate, increased or decreased blood pressure, seizure, shock, kidney failure, loss of consciousness, and even death may occur. Most reactions are easily treatable on site by our staff. In the case of a severe reaction, our personnel may call 911 and request additional assistance.
Rarely, intravenous gadolinium has been associated with fibrosis (scarring) of skin and connective tissues which can be severely debilitating. Our staff routinely screens all candidates for gadolinium injection for evidence of kidney or liver disease (at greatest risk for this side-effect).

Authorization and Consent

My signature on this document indicates that I have read the above warning regarding the possibility of an adverse reaction from the intravenous administration of contrast material, that all questions have been answered to my satisfaction, and that I consent to the intravenous contrast material injection.

Release

I remove my radiologist, technologists, nurse, and assistants, as well as Oklahoma Center for Orthopaedic & Multi-Specialty Surgery, from any liability regarding an adverse outcome stemming from that intravenous contrast material injection.

______________________________ ____________ ____________
Patient's Signature (parent or guardian if patient is a minor) Date Time

______________________________ ____________ ____________
Witness Signature Date Time

An Affiliate of INTEGRIS Health

Consent for Intra-articular Contrast Material Administration

Risks
For certain diagnostic examinations, FDA-approved contrast material (dye) may be injected into a joint space. Although rare, adverse reactions may occur. Reactions may be limited to the injection site an include redness, swelling, and pain, or be generalized and include shortness of breath, nausea, vomiting, chills, and hives. In more severe cases, irregular heart rate, increased or decreased blood pressure, seizure, shock, kidney failure, loss of consciousness, and even death may occur. Most reactions are easily treatable on site by our staff. In the case of a severe reaction, our personnel may call 911 and request additional assistance.

Authorization and Consent
My signature on this document indicates that I have read the above warning regarding the possibility of an adverse reaction from the intraarticular administration of contrast material, that all questions have been answered to my satisfaction, and that I consent to the intraarticular contrast material injection.

Release
I remove my radiologist, technologists, nurse, and assistants, as well as Oklahoma Center for Orthopaedic & Multi-Specialty Surgery, from any liability regarding an adverse outcome stemming from that intraarticular contrast material injection.

Please list any allergies: ____

____

Yes	No	Questions
❐	❐	Have you ever had contrast material (dye) injected into a vein or joint space?
❐	❐	If so, did you have an allergic reaction?
❐	❐	Do you suffer from renal (kidney) failure?
❐	❐	Are you on dialysis?
❐	❐	Do you have diabetes? How long?__________________
❐	❐	If so, do you take pills or shots for it?
❐	❐	Do you take Metformin (Glucophage, Glycon, Glucovance, Avandamet, or Metaglip)? How long?__________________
❐	❐	Do you have heart disease?
❐	❐	Do you have liver disease?
❐	❐	Do you have Sickle Cell disease?
❐	❐	Do you have multiple myeloma?
❐	❐	Do you have pheochromocytoma?
❐	❐	Do you have myasthenia gravis?
❐	❐	Do you suffer from asthma?
❐	❐	Are you pregnant?
❐	❐	Are you breast feeding?

❐ Radiologist made aware of any positive answers prior to examination.

________________________________ ______________ ______________
Patient's Signature or legal guardian Date Time

________________________________ ______________ ______________
Technologist's Signature Date Time

Arthrogram Consent/Patient History

Place Patient Sticker Here

Revised 12/10

An Affiliate of INTEGRIS Health

Consent for Conscious Sedation / Pain Management Therapy

Risks

In certain instances, conscious sedation and/or pain management therapy may be administered for diagnostic examinations. The medication is administered orally, injected intravenously, or injected intramuscularly. The patient will be monitored regarding status and well-being at all times during the procedure. It is used to treat claustrophobia or pain. Although rare, adverse reactions may occur. Reactions may be limited to the injection site and include redness, swelling, and pain, or be generalized and include shortness of breath, nausea, vomiting, chills, and hives. In more severe cases, irregular heart rate, increased or decreased blood pressure, seizure, shock, kidney failure, loss of consciousness, and even death may occur. Most reactions are easily treatable on site by our staff. In the case of a severe reaction, our personnel may call 911 and request additional assistance.

Authorization and Consent

I agree that I will not operate a motor vehicle or any heavy machinery for at least 8 hours after the administration of conscious sedation / pain management. I have brought a licensed driver to drive me home following the procedure. During this 8 hour period, I also agree not to return to work, make any important decisions, or sign any legal documents.

My signature on this document indicates that I have read the above warning regarding the possibility of an adverse reaction from the administration of conscious sedation / pain management therapy, that all questions have been answered to my satisfaction, and that I consent to the conscious sedation / pain management therapy.

Release

I remove my radiologist, technologists, nurses, and assistants, as well as OCOM Imaging from any liability regarding an adverse outcome stemming from the administration of conscious sedation / pain management therapy.

Please list any allergies to foods or medications: ____________________

____

Yes	NO	
[ ]	[ ]	Have you ever had conscious sedation / pain management therapy?
[ ]	[ ]	If so, did you have an allergic reaction?
[ ]	[ ]	Do you suffer from renal (kidney) failure?
[ ]	[ ]	Are you on dialysis?
[ ]	[ ]	Do you have glaucoma?
[ ]	[ ]	Do you have heart disease? Recent heart attack? Arrhythmia?
[ ]	[ ]	Do you have liver disease?
[ ]	[ ]	Do you have low blood pressure?
[ ]	[ ]	Do you suffer from asthma?
[ ]	[ ]	Are you pregnant?
[ ]	[ ]	Are you breast feeding?

____ ____________

Patient's Signature (parent or guardian if patient is a minor) Today's Date

____ ____________

Witness Signature Today's Date

An Affiliate of INTEGRIS Health

Medication History

Allergies and Reaction: ☐ NKDA or ______________________________

____

Food Allergies: ☐ NKA or ______________________________

Include all prescriptions, over the counter medications, inhalers, ointments, herbals and vitamins.

Medication Name	Dose	Route	Frequency	Last Dose (date & time)

______________________________ Patient Signature

______________________________ Date and Time

Patient Label

Medicare Secondary Payer Questionnaire

(Short Form)

1. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required. ALERT: If yes, bill SNF not Medicare)

   _____No _____ Yes

2. Are you receiving benefits from any of the following programs?

   Black Lung ____No____Yes
   Research Grant ____No____Yes
   Veteran Affairs ____No____Yes

3. Was the illness/injury due to a work related accident/condition?

   _____ No _____ Yes

   Date of injury/illness: _______________

4. Was illness/injury due to a non-work related accident?

   _____ No _____ Yes

   Date of accident: _______________

   What type of accident caused the illness/injury?
   _____ Automobile
   _____ Non-automobile

5. Are you entitled to Medicare based on:

   _____ Age
   _____ Disability
   _____ End Stage Renal Disease

6. Are you currently employed?

   _____ No _____ Yes

   If no, what is the date of retirement/disability?

   ____/____/______ (mm/dd/yyyy)

7. Is your spouse currently employed?

   _____ No _____ Yes

8. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

   _____ No _____ Yes

9. Does the employer that sponsors your GHP employ 20 or more employees?

   _____ No _____ Yes

I confirm that the above information is correct.

Patient Signature:______________________________ Date_______________

Please Print Name:______________________________

Patient's Communication Preferences Regarding their PHI

Telephone Communication Preferences

Home # ____________________

Work # ____________________

Mobile # ____________________

Other ____________________

Place Patient Identification Label Here

E-Mail Communication Preferences

Email Address ____________________

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Oklahoma Center for Orthopaedic & Multi-Specialty Surgery, LLC or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.

If an email address has been provided, Oklahoma Center for Orthopaedic & Multi-Specialty Surgery, LLC or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

____

____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name:	Telephone
Spouse		
Caretaker		
Child		
Parent		
Other		

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

____

____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Patient or Personal Representative Signature ____________________ **Date** ____________________

Printed Name ____________________ **Relationship to Patient** ____________________

FINANCIAL POLICY ACKNOWLEDGMENT

We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Therefore, we have addressed some of the most commonly asked questions.

Payment: For all services provided by the staff of OCOM, payment is due at the time of service. This includes your portion that insurance will not pay including any co-pay, deductible and co-insurance amounts. An important part of our service is making the cost of optimal care as easy and manageable for our patients as possible. We currently offer the following payment options:

1. MedDraft payment solution
2. Cash – includes money orders and personal checks
3. Visa/MasterCard/Discover/American Express
4. CareCredit® – subject to approval

*NOTE: MNET Financial is a preferred vendor who we partner with to collect balances after insurance has processed claims for services provided.

Regarding Insurance: At each visit, we will ask you for a copy of your insurance card and if you have any changes to your insurance. As a courtesy, we will bill your insurance company for the services provided to you. It is your responsibility, however, to know the benefits and conditions of your insurance plan. Some procedures require pre-certification or an authorization before the service is performed. If for some reason your insurance company fails to pay, we will expect you to pay the balance in full.

Patients without Insurance: Occasionally our patients may find themselves without health insurance coverage or find that their services are non-covered due to the terms of their insurance plan. Our policy is that payment in full is due prior to the time of service. Private pay rates are not available to Federal health care program beneficiaries except for services that are excluded from coverage.

Special Needs: We understand you may have a special need. It may be necessary to set up a payment plan for a patient requiring extensive procedures or services. *If this situation is necessary for you, please bring this to our attention as soon as possible so we can work with you to come up with a solution.*

Questions: Thank you for taking the time to read our financial policy. We hope this answers some of your questions. If you have any other questions, please call our Business Office at (405) 602-6595. We are here to help!

By signing below you are acknowledging receipt of OCOM's Financial Policy and Insurance/Billing Information.

______________________	______________
Patient and/or Legal Guardian Signature	Today's Date
______________________	______________
Print Patient Name	Patient's Date of Birth

Oklahoma Center for Orthopaedic Multi-Specialty Surgery

ADMISSION AGREEMENT

Place Patient Sticker Here

Consent for Admissions: I request and consent to admission to the Oklahoma Center for Orthopaedic Multi-Specialty Surgery Hospital

Consent to Medical Care: I request and consent to medical care and diagnostic procedures that my attending physician(s) or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in the Oklahoma Center for Orthopaedic Multi-Specialty surgery hospital is under the direction of my attending physicians(s) and the hospital is not responsible for acts of omission of my attending physician(s).

Unborn Child Coverage: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this hospital during this period of treatment.

Teaching Programs: I understand that this Oklahoma Center for Orthopaedic Multi-Specialty Hospital is a teaching hospital, and therefore, I understand that I may be seen and examined by supervised students and/or residents as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

Release of Information: I authorize the Oklahoma Center for Orthopaedic Multi-Specialty Surgery hospital to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of; or at the request of my attending physician, or his/her designees, of the Hospital. I authorize the Hospital, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law,** you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS).

Advanced Directive, Organ/Tissue Donor, Patient Rights, Privacy Notice: The patient, or his or her representative, hereby acknowledges having been provided with information regarding patient rights, advance directives, organ/tissue donation, and the facility privacy notice. The following documents have been executed.

Do you have an Advance Directive and/or Living Will? signed ☐ Yes ☐ No ☐ Copy on Chart OR ☐ Waiver
Do you have a signed DNR Form? ☐ Yes ☐ No ☐ Copy on Chart
Would like more information on Advance Directives? ☐ Yes ☐ No ☐ Information given
Do you have a Medical Durable Power of Attorney? ☐ Yes ☐ No ☐ Copy on Chart
Do you have a legal guardian? ☐ Yes ☐ No
Please provide
Name______________________________
Have you received a Copy of the Bill of Rights? ☐ Yes ☐ No
Have you received a copy of the Privacy Notice? ☐ Yes ☐ No
Have you received a copy of the Flu/Pneumonia Vaccine Education Packet? ☐ Yes ☐ No ☐ NA

I do_____ do NOT______ wish to be an organ or tissue donor. My family has _____ has NOT______ been informed of my decision.

Personal Property: I have been informed and understand the Hospital does not assume any responsibility for personal property that I choose to keep with me. I have been informed, however, that the Hospital does have a safe in which I can deposit personal property for safekeeping. I have been informed and understand that the Hospital will not be liable for any loss of my personal property unless it is placed in the safe maintained by the Hospital.

Physician Ownership: Your physician may be a partner in the ownership of this hospital. If you wish to see a list of owners, please notify the receptionist. This facility does not provide 24/7 physician coverage in-house; However the in-patient unit is staffed with a physician on weeknights from 7pm-7am. There a physician on call 24/7. In case of an emergency that exceeds the capability of this facility, you may be transferred to a local acute care hospital.

Payment for Medical Care: I agree that in consideration for the medical care I receive from the Hospital, its employees, agents, designees, or independent contractors. I guarantee full payment for all changes by the Oklahoma Center for Orthopaedic Multi-Specialty Surgery Hospital or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMC) with which Hospital has specifically entered into an agreement for payment of medical care provided by the Hospital or by its employees, agents, designees or independent contractors).

ASSIGNMENTS OF BENEFITS: I hereby authorize and assign payment to the Hospital of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all cost of my medical care provided at the Hospital or by its agents, designees, or independent medical contractors. Further, I understand that **Anesthesiology, Physician Services, Pathology** and some **Laboratory Services** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim

Photographing: I consent to video taping and/or photographs being taken for documentation in my medical records only. I may revoke this consent at any time.

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Release of Financial Information: I herby authorize the Oklahoma Center for Orthopaedic Multi-Specialty Surgery Hospital, its employees, agents, designees, or independent contractor to disclose any and all information regarding the medical care I received on the admission to this Facility or through its employees, agents, and designees, or independent contractors to any third party payor responsible for paying the costs of my medical care and any part thereof.

I have reviewed this Admission Agreement and fully understand its contents and implications.

____

Signature of Patient, Parent, Legal Guardian, Representative Guardian | Date/Time | Please Print Name of Patient, Parent,

____

Signature of Guarantor | Relationship to Patient | Date/Time | Please Print Name of Guarantor

____

Signature of Witness | Date/Time | Please Print Name of Witness

If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or a parent or legal guardian of a child.

Oklahoma Center for Orthopaedic
Multi-Specialty Surgery

ADMISSION AGREEMENT

Place Patient Sticker Here