WELCOME TO
OKLAHOMA SHOULDER CENTER, PLLC

PATIENT INFORMATION

RECORD # DATE:

PATIENT NAME:

ADDRESS:

CITY STATE ZIP

EMAIL

CONSENT TO EMAIL ____YES ____NO

AGE: DATE OF BIRTH: ____/____/____

___LEFT HANDED ___RIGHT HANDED ___ MALE ___ FEMALE

___ SINGLE ___ MARRIED ___ WIDOWED ___ SEPARATED ___ DIVORCED

PATIENT SS#:

OCCUPATION:

EMPLOYER:

EMPLOYER ADDRESS:

EMPLOYER PNONE:

SPOUCSE'S NAME: SPOUCE #

TRICARE ONLY:
IS THIS A LOD INJURY? ____YES ____NO

RACE ___WHITE ___ AFRICAN AMERICAN ___ CAUCASION ___ OTHER _____

ETHNICITY ___ FILIPINO ___ HISPANIIC/LATINO ___ NOT HISPANIC/NOT LATINO

LANGUAGE ___ ENGLISH ___ SPANISH ___ OTHER _____

WHOM MAY WE THINK FOR REFERRING YOU

DOCTOR:

ADDRESS: PHONE:

PHONE INFORMATION

CELL# ( ) NOME: ( )

WORK# ( ) ext.

IN CASE OF AN EMERGENCY:
NAME:

RELATIONSHIP:

CELL# ( ) HOME: ( )

WORK# ( ) ext.

WERE YOU INJURED AT WORK? ____YES ____NO

WERE YOU INJURED IN AN AUTO ACCIDENT? ____YES ____NO

IF YES TO EITHER QUESTION, PLEASE COMPLETE THE INFORMATION BELOW:

DATE OF INJURY_____ ADJUSTER NAME:_____

ADJUSTER PHONE NUMBER:_____

CASE MANAGER NAME:_____

CASE MANAGER PHONE NUMBER:_____

STATUS OF CLAIM _____OPEN_____ CLOSED

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

PRIMARY POLICY HOLDER: _____

PRIMARY POLICY HOLDER DOB: ___/___/___

POLICY ID:

POLICY GROUP #:

SECONDARY INSURANCE CARRIER: _____

SECONDARY POLICY HOLDER NAME: _____

SECONDARY POLICY HOLDER DOB**:** ___/___/___

POLICY ID:

POLICY GROUP #:

AUTHROIZATION ASSIGNMENT AND RELEASE

THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO **DR.ELIZABETH NOLAN** ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I'M 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 DATE

MEDICARE PATIENT AUTHROIZATION ASSIGNMENT AND RELEASE

I REQUEST THAT PAYMENT OF COVERED MEDICARE BENEFITS BE MADE ON MY BEHALF TO **DR. ELIZABETH NOLAN** FOR ANY SERVICES FURNISHED ME BY THAT PHYSICIAN. I AUTHRORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMAIN THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. IF OTHER HEALTH INSURANCE IS INDICATED, MY SIGNATURE AUTHORIZES RELEASING OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. THIS PHYSICIAN 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 BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

_____ _____/_____/_____

MEDICARE PATIENT SIGNATURE DATE

OKLAHOMA SHOULDER CENTER, PLLC

If you have **Medicare Part A** please provide us with a copy of your card incase surgery is needed.

Thank You!

OKLAHOMA SHOULDER CENTER, PLLC

HEALTH HISTORY
(CONFIDENTIAL)

NAME: _____TODAY'S DATE: ____/____/____

AGE_____ DOB:____/____/___ DATE OF LAST PHYSICAL EXAM:____/____/____

PRIMARY CARE DOCTOR:_____ PRIMARY CARE DOCTOR PHONE:_____

WHAT IS YOUR REASON FOR THIS VISIT?_____

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

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE PAIN, WEAKNESS, NUMBNESS IN:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Apetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hungar
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling in ankles
- ☐ Varicose veins

EYE/EAR/NOSE/THROAT

- ☐ Bleeding gums
- ☐ Blurred visión
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double visión
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistant cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

ALL PATIENTS

DO YOU HAVE YOUR MEDICAL MARIJUANA LICENSE?

- ☐ YES
- ☐ NO

DO YOU SMOKE?

- ☐ YES
- ☐ No

WOMEN ONLY

ARE YOU PREGNANT? _____

DUE DATE: _____

CONDITIONS (Check the conditions you have or have had in the past.)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Non Prescription Drugs
- ☐ Chenical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphyserma
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ Herbal Supplements
- ☐ High Cholesterol
- ☐ HIV positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Thyroid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Diseases

MEDICATIONS (List medications you are currently taking.)	ALLERGIES (to medications or substances) MEDICATION	REACTION

PHARMACY NAME:_____ PHONE NUMBER:_____

(All information is strictly confidencial)

FAMILY HISTORY (Fill in the health information about your family.)						
RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	CHECK BOX IF ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING: **DISEASE:**	**RELATIONSHIP TO YOU:**
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Heart Disease, Strokes	
					☐ Diabetes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ 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 us approximate dates:_____

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:
☐ Caffeine	☐ Stress
☐ Tobacco	☐ Hazardous Substances
☐ Drugs	☐ Heavy lifting
☐ Other	☐ Other

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

Signature_____Date____/____/____

Signature_____Date____/____/____

Oklahoma Shoulder Center PLLC
Betsy M. Nolan MD
725 NW 11th St
Oklahoma City, OK 73103
Ph: 405-278-8006
Fx: 405-290-7388
www.okshoulder.com

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 core 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 Its 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, symptom, 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 tor services. Payment Is due In full when services are rendered.

NAME:_____DATE:_____

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME:_____ MEDICAL RECORD #:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

I hereby authorize: OKLAHOMA SHOULDER CENTER, PLLC

Name of Person/ Organization Disclosing PHI

To release the following information to:_____

Name and address of Person/Organization receiving PHI

Information tobe shared:

□ Psychotherapy Notes (if checking this box, no other boxes may be checked)

□ Entie Medical Record

□ Billing Information for_____

□ SubstanceAbuse Records

□ Mental Health Records

□ Medical information compiled between_____ and_____

□ Other:_____

The Information may be disclosed for the following purpose(s) only:

□ Insurance □Continued Treatment □Legal □ At my or my representative's request

□ Other:_____

I **understand that by voluntarily signing this authorization:**

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits. signing this authorization will not affect my eligibility for benefits, treatment, enrollment o payment ofclaims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HI or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorizatioi1at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following:_____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

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Ph: 405-278-8006
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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, or 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 " HIPM " 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 any 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** mean providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would Include physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverages, 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 reference to Individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternative 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 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 the those related to disclosures to family member's, 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 healthInformation.
- 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 a 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 you for filing a complaint.

Please contact us for more information.

For more information about HIPPA 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 ("HlPAA"), 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's 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 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

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article I : **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 un authorized or were improperly, negligently, or incompetently rendered, will be determined 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. ln 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 partner, associates, as 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 di tress 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 hall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrator s 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 e pen es of the arbitration incurred or approved by the neutral arbitrator. not including council fees or witness fee, 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 hall have the absolute right to arbitrate separately the i sues 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 exiting 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 provider 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 (I) on the date notice thereof I received, the claim, if asserted in a civil action, would be barred by the applicable Oklahoma statute of limitation, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators hall be governed by the Oklahoma laws relating to arbitration.

Article 5: **Intent:** It is the intent of this agreement to apply to all medical services rendered any time for any condition. This agreement ls effective as of the date of the first medical services provided.

Article 6: **Severability:** If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

l understand that J have the right to receive a copy of this arbitration agreement upon requesting one. By my signature below, l acknowledge that I have received or have waived receipt of a copy

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANV ISSUE IN DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GNING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____ Date:_____
Patient's or Representative's Signature

_____
Patient's Printed Name

By: Oklahoma Shoulder Center, PLLC Dated: 01/01/2016
(Typed company name and date is to act as signature of practice for this document only.)

A signed copy of this document is to be given to Patient upon request. Original is to be filed in Patient's medical records.

Pain Management Policy

The appropriate management of chronic pain should rely primarily on non-opioid therapies and should incorporate a multi-model treatment plan to obtain the best outcome for the patient. As per Oklahoma state laws established in 2018, treatment of acute pain, such as normal anticipated pain after surgery is limited to a 7day prescription for narcotic medications with only one refill allowed, and no longer allowed after 2 weeks.

Given these restrictions and lack of lab and other infrastructure, it is the policy of this practice that no narcotic medication can be prescribed after the 2 week post-operative period.

Your signature affirms that you have read and agree to abide by this policy. Any pain requiring narcotic medication past the 2 week acute pain window, as defined by Oklahoma law, is considered chronic pain management. This office does not provide chronic pain management.

Patient's Signature:_____

Patient's Printed Name:_____