



### Insurance Verification

All fields must be completed in order to be seen by a physician.

Patient Name: \_\_\_\_\_ Sex:  Male  Female

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Guarantor Name: \_\_\_\_\_ Sex:  Male  Female

Guarantor Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Guarantor SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Patient Address: \_\_\_\_\_  
Street Apt

City State Zip Code

Patient Phone: Home: ( ) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

Work: ( ) \_\_\_\_ - \_\_\_\_ Occupation: \_\_\_\_\_

Cell: ( ) \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ ( ) \_\_\_\_ - \_\_\_\_  
Name Relationship to Patient Phone

Primary Insurance Company Name and Address: \_\_\_\_\_  
Company Name

Street Suite

City State Zip Code ( ) \_\_\_\_ - \_\_\_\_  
Phone Number

Personal ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Subscriber Name (Insured): \_\_\_\_\_

Subscriber SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance Company Name and Address: \_\_\_\_\_  
Company Name

Street/PO Box Suite

City State Zip Code ( ) \_\_\_\_ - \_\_\_\_  
Phone Number

Personal ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Subscriber Name (Insured): \_\_\_\_\_

Subscriber SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Referral Source Information

How did you hear about us? Who were you referred by?

Physician Name: \_\_\_\_\_ Physician Address: \_\_\_\_\_

Physician Phone: ( ) \_\_\_\_ - \_\_\_\_ Physician City/State: \_\_\_\_/\_\_\_\_

Phone Book: White or Yellow  Athletic Trainer: \_\_\_\_\_  www.OSOI.com  
(Circle One) Name of School

Friend: \_\_\_\_\_  Advertisement: \_\_\_\_\_  Website: \_\_\_\_\_  
Name Where did you see our ad? Address

Other: \_\_\_\_\_



HISTORY OF PRESENT ILLNESS FOR BACK AND NECK PAIN

- 1. On a scale from 1 to 10, how bad is your pain? 1 2 3 4 5 6 7 8 9 10 No Pain + + + + + + + + + + Severe Pain
2. How long have you been unable to perform normal activity?
3. On what approximate date did your present pain start?
4. Did your pain start gradually or suddenly?
5. When during the day is the pain the worst? \*...the best?
6. What previous problems have you had with your back, neck, legs or arms?
7. In percentages, how much of the pain is in your back/neck and how much is in your legs/arms?
8. Is it the result of an accident? Loss of bladder/bowel?
9. Please describe how your pain started:
10. Do you have an attorney helping you?
11. How far can you walk before you have to rest?
12. What aggravates your pain the most?
13. Have you had myelograms (x-rays of the spine with die injection) MRI's or CT's
14. What treatments have made your pain better?
15. What treatments have made your pain worse?
16. Have you seen another physician for this problem?
17. Have you changed jobs or stopped work because of this pain?
18. Are you under any pressure at home? ...at work?

Medical History / Review of Systems / Social History

- Heart Trouble Chest Pain Stroke/Dizziness Stomach Ulcers/Reflux Blood Diseases (Anemia etc...) Headaches/Vision Changes Diabetes (If yes, how long?) Glaucoma Abnormal Bleeding Tendencies Lung Disease Shortness of Breath/Difficulty Swallowing Anticoagulant Therapy Blood Vessel Disease (Phlebitis) Pregnant (If yes, # of months) Depression/Anxiety Other medical illness
Do you drink alcoholic beverages? (If yes, how often?) Married Exercise Regularly Employed Hepatitis (If yes, which type?) Cancer (If yes, where?) High Blood Pressure Thyroid Disease Positive HIV/AIDS blood test Arthritis (If yes, which type?) Abnormal Anesthetic Reaction Kidney Disease Tobacco (If yes, daily usage) Overall health is good
Medical History Immediate Family (parents, grandparents, siblings): Heart Disease Cancer Diabetes High Blood Pressure Other:



**HISTORY OF PRESENT ILLNESS FOR BACK AND NECK PAIN**

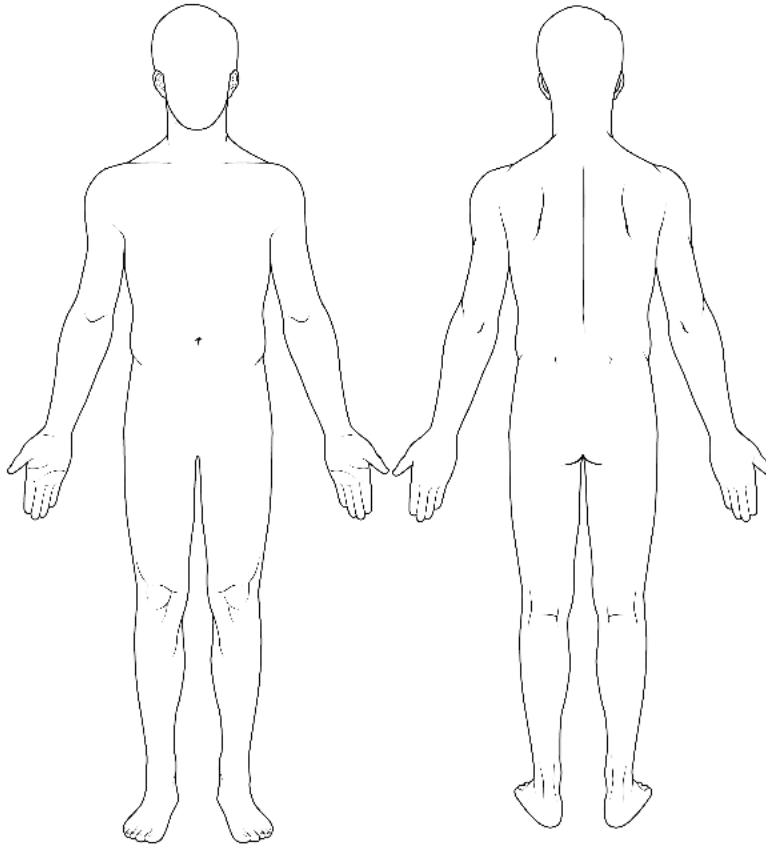
This form will greatly aid the physician in your health care.

On the following diagram, mark the areas on your body where you feel the following sensations:

**(Mark the diagram using the following symbols):**

Ache      Numbness      Pins & Needles      Burning      Stabbing  
 ++++      =====      ooooo      XXXX      /////

**Please use this symbol for where the pain first started: ^ ^ ^ ^ ^**



**Past Surgical History**

Please indicate all previous surgeries you have had.

Year	Procedure Done	Surgeon's name.../and where?

**Current Medications**

Please list all prescription and over-the-counter medicines

Name	Name	Name

**Allergies to Medications, foods or other substances**

Name the medication/item      Indicate the reaction you had


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### AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Sports and Orthopedics Institute 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 and Orthopedics Institute 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 and Orthopedics Institute 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 and Orthopedics Institute, its agent and its employees from liability in connection with the release of the information contained therein.

**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 health care 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 Department of Health, or by law.

### 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 and Orthopedics Institute. **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 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 and Orthopedics Institute 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** \_\_\_\_\_  
(PATIENT)

**DATE** \_\_\_\_\_

**OR** \_\_\_\_\_  
(NEAREST RELATIVE OR  
RESPONSIBLE PARTY)

**POLICYHOLDER'S  
SIGNATURE** \_\_\_\_\_

\_\_\_\_\_  
(RELATIONSHIP TO PATIENT)



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 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 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.

If your injury was due to a Motor Vehicle Accident or any other "Third Party Liability" accident, you will be set up on a self-pay account requiring a down-payment of \$300.00. If charges exceed \$1,500.00, 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 not all OSOI Physicians will accept third party/MVA patients.

**Additional Charges**

There is a \$20.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion. There is a \$20.00 charge for any returned check. This charge is applicable per returned check. Returned checks may be submitted to the District Attorney's office. There will be a \$20.00 charge assessed to your account for No-Showing an appointment or for cancellations within 24 hours of your scheduled appointment.

**Gemini Financial Solutions**

In the interest of good business practice, the desire to continue to provide quality health services and maintain fiscal responsibility, Oklahoma Sports & Orthopedics Institute has developed a policy regarding partial payments for outstanding accounts. You are responsible for payment of all medical treatment and related services provided by Oklahoma Sports & Orthopedics Institute. As a service and out of consideration to you, this office will file insurance claims for all covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance company's maximum allowable reimbursement. You will be responsible for any deductible or co-payment amounts and any non-covered services incurred at the time of service. **All accounts are considered due, after payment from insurance company is received.** Payments can be made by cash, check, money order, Visa, MasterCard, American Express, or Discover card. 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.

**In keeping with our commitment to serve our patients, Oklahoma Sports & Orthopedics Institute has secured arrangements for partial payments for your convenience. The following is the billing procedure for Oklahoma Sports and Orthopedics Institute**

- A) Initial balance due will be sent to the patient for an attempt to collect the balance in full.
- B) In the event payment in full is not received by Oklahoma Sports & Orthopedics Institute within 30 days of said statement, the following will automatically occur:
  - 1) This amount and any future balances due will be handled by our billing agent, Gemini Financial Services, LLC (GFS)
  - 2) The patient shall be billed a \$15.00 annual administrative fee by GFS to cover administrative and set up costs.
  - 3) The patient shall be billed 1.375% monthly service fee on the outstanding balance.
  - 4) The patient will be required to pay the GREATER of \$30.00 or 3% of the outstanding balance each month until the balance is paid in full.

Again, thank you for allowing Oklahoma Sports and Orthopedics Institute to participate in your care.

Sincerely,  
OSOI 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: \_\_\_\_\_