9821 S. May Ave Ste. B
Oklahoma City, OK 73159
Phone: 405-631-4263
Fax: 405-703-1583

Patient Information

Patient's Legal Name: Last	First	M.I.	Sex:	DOB:	Age:
Social Security Number:	Marital Status: ____Single ____Married ____Widowed ____Divorced				
Patient's Address:	Employment Status: ___Employed ____Full-time Student ____Part-time Student				
City:	State:	Zip Code:	Referring Physician:		
Home Phone:	Work Phone:	Cell Phone:			
Ethnicity: ___Hispanic ___Non-Hispanic ___Declined	Race: ___White ___Asian ___Black ____Pacific ____Native American ____Multiple	Preferred Language:			

Insurance Information

Name of Primary Insurance Company:	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:
Secondary Insurance (if applicable):	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:

Employer 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:

Who Referred You? (Please circle one)

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

Insurance Authorization and Assignment

I request that payment of benefits be made on my behalf to Oklahoma Center for Spine and Pain Solutions for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply (if applicable). I authorize any holder of medical of other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefits be paid to the party who accepts assignment. Any overpayment will be applied to any outstanding balance within OCSPS. I understand that it is mandatory to notify the healthcare provider. I have answered the questions and have read and understand the terms of assignment and release of information. I promise to pay for services rendered.

Signature:	Date

Oklahoma Center for Spine and Pain Solutions

9821 S. May Ave Ste. B, Oklahoma City, OK 73159

Accident Questionnaire

Is your chief complaint the result of an accidental injury? YES NO
If yes, what is the date of that injury? ____

Where did that accident occur?

____
____
____
____

Describe how the accident occurred (Please give full details):

____
____
____
____
____
____
____

Have you filed a claim regarding this injury with any of the following?

_____ Workers Compensation
_____ Motor Vehicle Insurance Company
_____ Homeowners Insurance Company

If not, do you plan on filing a claim in the future? YES NO

Have you sought the advice of an attorney? YES NO

If yes, please provide the attorney's information:
Name: ____
Address: ____
Phone Number: ____
Fax Number: ____

Patient or Legal Guardian's Signature: ____

Print Name: _____________________________________ Date: _______________________

Oklahoma Center for Spine and Pain Solutions

9821 S. May Ave Ste. B, Oklahoma City, OK 73159

NOTICE TO PATIENTS

Privacy Notice:

This document is the Oklahoma Center for Spine and Pain Solution's Notice of Privacy Practices. Please print and sign your name below to acknowledge that you have received a copy of our Privacy Notice at the date and time indicated below. If you have any questions about our Privacy Practices please contact:

Privacy Officer
Oklahoma Center for Spine and Pain Solutions
9821 S. May Ave Ste. B
Oklahoma City, OK 73159
405-631-4263

Patient or Legal Guardian Signature: ____

Print Name: ______________________________ Date: ________________________

Witness: ____

Date and Time Notice was Obtained: ____

Oklahoma Center for Spine and Pain Solutions

9821 S. May Ave Ste. B, Oklahoma City, OK 73159

Authorization to Release Information

NOTICE: THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) ALLOWS YOU TO REQUEST THAT WE COMMUNICATE WITH YOU ABOUT YOUR PERSONAL HEALTH INFORMATION IN A WAY THAT IS CONFIDENTIAL. PLEASE USE THIS FORM TO DESCRIBE THE LIMITATIONS ON USE AND DISCLOSURE THAT YOU ARE REQUESTING. AS STATED IN THE LAW, WE ARE NOT REQUIRED TO HONOR YOUR REQUEST. IF WE ARE TO HONOR YOUR REQUEST WE WILL COMPLY WITH YOUR REQUEST UNLESS THE INFORMATION IS NEEDED TO PROVED EMERGENCY TREATMENT, PAYMENT, OPERATIONS, AND IF LEGALLY REQUIRED BY APPLICABLE FEDERAL OR STATE LAW.

Patient Name: ____DOB:_______________________

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: ____________________________

__________ (Initials) I prohibit any/all information to be given out including: appointments, treatment plans, medications and account information.

I understand that this authorization will remain in effect until I revoke this authorization in writing.

____ ________________________

Signature of Patient, Parent or Legal Guardian **Date**

Oklahoma Center for Spine and Pain Solutions

9821 S. May Ave Ste. B, Oklahoma City, OK 73159

Financial Policy

The intent of this agreement is to establish an understanding between the office/physicians of Oklahoma Center for Spine and Pain Solutions and the patients and/or guarantors regarding finances, and account balances. Please read the following:

- **For Patients with Insurance:** Health insurance is in a state of constant change. Each carrier has many different types of plans, the plans are continually revised, reimbursement requirements are changed and deductibles are continuing to increase. It is not possible for our office to know all the details of every plan. Although we make every effort to ensure we have the correct referrals, approvals and pre-authorizations for each patient it is imperative, you, as the subscriber, be familiar with your specific insurance plan. ***Medical fees not covered by insurance are the responsibility of the patient and will be billed accordingly.*** You must provide our office with a copy of your insurance card at your initial appointment or you will be responsible for all charges at the time of service. If your insurance changes, you must provide our office with an updated copy of your insurance card in order to properly submit claims to your insurance company. ***All co-pays, deductibles and co-insurance amounts are due at the time of service.***
- **Medicare Patients**: We will bill Medicare for you. We will also bill secondary insurance carrier for you.
- **Surgery Fees:** ***All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery.*** Full or partial payment may be required prior to your surgical procedure. Prior authorization may be required by your carrier which our office will obtain prior to scheduling your surgery.
- **Non-covered Services**: Any care not paid for by your existing insurance coverage will require payment in full at the time of service.
- **Personal Injury Cases**: This office does in some cases, bill for auto accidents or other liability or lawsuit related cases prior to your appointment, we will need the auto insurance/3rd party liability insurance information, including liable party, mailing address for claims, telephone number, claim/policy number and date of injury. If you are represented by an attorney, we will need your attorney name, address and phone number. We will file a lien on any services rendered to you, however, if your case is not settled, in a timely manner, you will be responsible for payment in full.
- **Worker's Compensation**: If your injury is work related, we will need the case number, insurance carrier name, adjustor name, telephone number and date of injury, prior to your visits, to obtain authorization to treat and bill the worker's compensation company for all charges incurred in our office. If your case is pending or NOT authorized, you are responsible for all charges until a determination has been made regarding your case.
- **Missed Appointments**: In fairness to other patients and the doctor we request that at least 24 hours to cancel appointments. If missing appointments becomes excessive, you will be assessed a 'no-show' fee.
- **Special Forms/Disability Forms/Accident Forms**: There will be a charge for all forms to be filled out on behalf of the patient. Payment is required when forms are dropped or, faxed to our office or mailed to our office. Forms will not be completed until payment is made. Our office will quote you a price after reviewing the form. This is a $50 flat fee.
- **Letters/Narratives**: Any patient requests for a "special letter" or "narrative" on their behalf will be charged a flat rate of $600. Narrative in excess of 6 pages will charged an additional $150 per page. Payment for these requests are due five days prior to being dictated. This type of correspondence will not be dictated until payment is received.

Upon signing this agreement, you understand all above information and are responsible for maintaining cooperation with this agreement. If you have any questions/concerns, please express those prior to signing this agreement.

____ ____________________

Signature of Patient, Parent or Legal Guardian **Date**