DIESSELHORST
SPORTS & ORTHOPEDICS

10914 Hefner Pointe Drive
Suite 200
Oklahoma City, OK 73120

Matthew M. Diesselhorst, MD
Phone: 405.463.3337
Fax: 405.463.3338

Kingfisher Clinic Mercy
1000 Hospital Circle
Kingfisher, OK 73750

Date: ____________________

Name: (Last)_____________________(First)_________________________(Middle)_________________________

Date of Birth: ___/___/___ Age:_____ Sex: ( )M ( ) F

Phone #: __________________ Cell: __________________ SSN: ________________________

Address/City/State/Zip: ____

Email Address: ____

Employer: ___________________________________ Phone #: _____________________________

School if student: ___________________________________ ( ) Full time ( )Part time

Primary Care Physician: ____

Referred by: ____

IN CASE OF AN EMERGENCY, I GIVE PERMISSION TO NOTIFY:

Name: ____________________________________ Home #: ____________________________________

Relationship: ______________________________ Cell #: ______________________________________

If patient is a minor please give parental or guardianship information:

Parent/Guardian: ____

Relationship: ______________________ SSN: _______________________ DOB: ____________________

HEALTH INSURANCE INFORMATION: PLEASE GIVE INFORMATION ABOUT THE HOLDER OF INSURANCE

Primary:

Insurance Company: __________________________

Relationship to Patient: _______________________

SSN: ____

DOB: _______________________________________

Policy/ID #: __________________________________

Group #: _____________________________________

Employer: ___________________________________

Secondary:

Insurance Company: _________________________

Relationship to Patient:________________________

SSN: ____

DOB: _______________________________________

Policy/ID #: __________________________________

Group #: ____________________________________

Employer: ___________________________________

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The CMS Meaningful use initiative requires we ask certain demographic information questions (below).

_____ Do not wish to answer the following questions:

Language Choice: ______________________________ Race: ____

Is this a Work Related Accident? ( )Yes ( )No If yes, list Employer and/or Adjusters name and #:__

____

Is this an Auto-Related Accident? ( )Yes ( )NO If yes, please indicate how your account will be billed:
( ) MVA(Self pay) ( ) Health Insurance

If yes, list RESPONSIBLE PARTY, INSURANCE COMPANY, ADJUSTORS NAME, CLAIM #, AND PHONE #. IF UNKNOWN PLEASE WRITE "UNKNOWN"

____

____

NOTE: Be advised all MVA (self pay) accounts require lien filing process on accounts with charges over $200. MVA liens will not be filed for medical charges if you are Medicare/Medicaid recipient.

Are you represented by an attorney? ( )Yes ( )No If yes, list Attorneys Name and phone #:

____

Please list how you would like to be contacted for appointment reminders:
( ) Text message ( ) Voicemail Phone #: ____

Who may we talk to on your behalf?

____________(Initial) I permit Diesselhorst Sports and Orthopedics to discuss health information in person or by phone with the following family members or friends. Release of information under this document is limited to verbal discussion with my health care provider. This document does not permit release of any written health information to the individuals named below.

Name	Phone #	Relationship

I attest that the information stated on this document is true and correct to the best of my knowledge, and agree to contact and inform Diesselhorst Sports and Orthopedics of any changes to the information stated herein.

____

Signature of Patient/Parent/Guardian (relationship is required) Date

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What is your current: Height: ________________ Weight: ________________

Are you in Pain Management? ( )Yes ( )No Dr. Name: ________________
Do you have a Cardiologist? ( )Yes ( )No Dr. Name: ________________
Do you have a pacemaker? ( )Yes ( )No Dr. Name: ________________

What do you expect to be seen for today? ________________

Which side of the body is being seen? ( )Right ( )Left
Which body part is being seen? ( )Head ( )Neck ( )Shoulder ( )Elbow ( )Wrist ( )Hand ( )Finger ( )Back ( )Hip ( )Knee ( )Ankle ( )Foot ( )Toes ( )Other: ________________

Was this injury/illness due to an accident? ( )Yes ( )No If yes, what type? ( )Work ( )MVA
Date of injury/illness began: ________________

REGARDING CURRENT INJURY/ILLNESS:
Have you been treated at a hospital or by another physician for this injury/illness? ( )Yes ( )No
If yes, by whom and when? ________________
Have you had an: ( )Xray ( )MRI ( )CT Scan ( )Ultrasound ( )EMG ( )Other
If yes, list where and when: ________________
Have you had surgery for current injury? ( )Yes ( )No
If yes, list Doctor name and Date: ________________
Are you currently pregnant? ( )Yes ( )No

ALLERGIES:
Do you have any drug allergies? ( )Yes ( )No If yes, name of allergies: ________________
Do you have any allergies to the following: ( )Latex ( )Adhesive Tape ( )Iodine ( )Metal ( )Other: ________

PHARMACY INFORMATION:
What is your preferred pharmacy?
Name: ________________ Location: ________________

CURRENT MEDICATIONS(attach list as needed):

________________ mg________________
________________ mg________________
________________ mg________________

CURRENT REVIEW OF SYSTEMS: (Check all that apply)

( )Abdominal Pain ( )Difficulty Swallowing ( )Increased Thirst ( )Persistent Cough
( )Bleeding ( )Easily Bruising ( )Increased Hunger ( )Rash
( )Chest Pain ( )Emotional Disturbances ( )Insomnia ( )Shortness of Breath
( )Convulsions ( )Eyes or Vision Problems ( )Joint Pain ( )Shortness of breath(laying down)
( )Seizures ( )Fecal Incontinence ( )Nausea/Vomiting ( )Skin Problems
( )Decreased Motion ( )Fever/Chills ( )Night Sweats ( )Urinary Retention
( )Depression ( )Headaches ( )Poor Balance ( )Weakness

MEDICAL HISTORY: (Check all that apply)

( )ADD/ADHD ( )Failure to thrive ( )Kidney Disease ( )Strep throat
( )Allergic Rhinitis ( )GERD ( )Lead Poisoning ( )Stroke
( )Anemia ( )Headache ( )Liver Disease ( )Tuberculosis (ACTIVE TB)
( )Arthritis ( )Hearing Loss ( )Lung Disease ( )UTI
( )Asthma ( )Heart Murmur ( )Obesity ( )Varicella
( )Cancer ( )High Blood Pressure ( )Otitis Media ( )Vision Impairments
( )Clotting Disorder ( )High Cholesterol ( )Pneumonia
( )Diabetes Mellitus ( )HIV/Aids ( )Scoliosis
( )Eating Disorder ( )IBS/IBD ( )Seizure
( )Eczema ( )Jaundice ( )Sickle Cell Anemia
Other: ____

SURGICAL HISTORY: (check all that apply)

( )Appendectomy ( )Fracture Surgery ( )Small Intestine Surgery
( )Brain Surgery ( )Gastrostomy ( )Spine Surgery
( )Cosmetic Surgery ( )Heart Surgery ( )Tonsillectomy
( )Ear Tubes ( )Hernia Repair ( )Umbilical Hernia
( )Eye Surgery ( )Lymph Node Biopsy ( )VP shunt
Other: ____

FAMILY HISTORY: (List relatives with conditions. For example: Mother ,Father, Brother, Sister, Paternal/Maternal Grandparents)

( )Alcohol Abuse____________ ( )Drug Abuse_________________ ( )Mental Illness__________________
( )Arthritis__________________ ( )Early Death_________________ ( )Miscarriages__________________
( )Birth Defect_______________ ( )Heart Disease_______________ ( )Suicide_______________________
( )Cancer___________________ ( )Hyperlipidemia______________ ( )Suicide Attempt________________
( )COPD____________________ ( )Hypertension_______________ ( )Vision Loss_____________________
( )Depression_______________ ( )Kidney Disease______________
( )Diabetes_________________ ( )Learning Disabilities__________
( ) Other: ____

SOCIAL HISTORY:

Do you drink alcohol? ( )Yes ( )No If yes, How often?____

Smoking: ( )Everyday ( )Some days ( )Never Smoked ( )Former Smoker-Quit in__________

Smokeless Tobacco: ( )Yes ( )No ( )Never Former smokeless tobacco- Quit tobacco in____________

By signing this medical history form, I attest that the information stated within is true and current medical history to the best of my knowledge, and agree to contact/inform Diesselhorst Sports and Orthopedics medical staff or my provider of any medical changes to the information stated herein.

____________________________________ ____________________________________

Signature of Patient/Parent/Legal Guardian Date

Print Name of Parent or Legal Guardian, if patient is a minor: ____________________________________

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POLICY FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Print Patient Name:____DOB: _____________________

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management and/or anxiety management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly, as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines and stimulants may cause addiction, and is only one part of a complete treatment plan.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine not prescribed to me.
2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
4. I will not increase my medicine until I speak with my doctor or nurse.
5. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
6. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
7. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
8. I agree to come to the office for a pill count at any time if asked by my doctor.
9. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
10. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test, and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit, and again randomly through the course of my treatment.
11. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
12. I have been informed by my physician about narcotic effects, including the normal physiological effects of tolerance (where I might need to take more medication to obtain the same pain relief), and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
13. I understand that narcotics can adversely affect my judgment in making business decisions, and in operating equipment such as an automobile.
14. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
15. I understand that there will be a trial period for this medication regime. Within this period, my case will be reviewed. If there is no evidence that I am improving, or that progress is being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician.

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16. Non-payment of services rendered may result in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

Refills

- I understand that refills of narcotic medication will be given only during my regularly scheduled appointment, or once monthly by telephone if the current prescription has been correctly used. If the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.
- I understand that refills will be made only during regular office hours—Monday through Thursday, 8:00AM-4:30 PM and Friday 8:00AM-12:00 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 3 business days is required.
- I must keep track of my medications. No early or emergency refills may be made.
- Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before a new prescription will be written.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is________________________________.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other physician they see that they obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if narcotics have been obtained from another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must bring this medicine to the office in the original bottle, even if there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way, and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

I have talked about this agreement with my doctor and I understand the above rules.

Patient's signature____ Date ______________________

Physician's signature ___________________________________

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AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Diesselhorst Sports & 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 Diesselhorst Sports & 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 Diesselhorst Sports & Orthopedics 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 Science and Orthopaedics, its agents and its 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 at Diesselhorst Sports & Orthopedics. 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 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 Diesselhorst Sports & Orthopedics 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 ____________________________________ DATE ____________________________
(Patient)

OR ______________________________________
(Nearest relative or responsible party)

_______________________________________ 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 exposures, release pursuant to an order of the court of the Dept. 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 an order of the court, or the Dept. of Health, or by law.

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Diesselhorst Sports & Orthopedics

A DIVISION OF THE PHYSICIANS' GROUP

FINANCIAL POLICY

Thank you for choosing Diesselhorst Sports & Orthopedics (DSO) are you healthcare provider. At DSO, we are dedicated to providing the highest quality, most cost effective care.

In addition to accepting traditional insurance plans and Medicare we are contracted with numbers 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 your current insurance card, or any other information that is required by your insurance company to each appointment. 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, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.463.3337 to make financial arrangements. Please be aware that charge 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 (MVA) you will be setup 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 the third party in order to ensure payment to the physician. **Please note that not all DSO/TPG Physicians will accept third party/MVA patients.**

There is a $35 charge any FMLA, disability or accidental form completed. This charge is applicable per form completed any is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at OCOM, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, than you for allowing Diesselhorst Sports & Orthopedics to participate in your care.

Sincerely,

DSO 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____

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DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Oklahoma Center for Orthopaedic and Multi-Specialty Surgery, LLC, this information is being provided to you to help you make an informed decision about your health care.

1. Dr. Matthew Diesselhorst has an ownership interest in Oklahoma Center for Orthopaedic and Multi-Specialty Surgery, LLC.

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 Oklahoma Center for Orthopaedic and Multi-Specialty Surgery, LLC. 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 Oklahoma Center for Orthopaedic and Multi-Specialty Surgery, LLC. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at ocomhospital.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 Oklahoma Center for Orthopaedic and Multi-Specialty Surgery, LLC.

____
Signature of Patient

____
Signature of Parent or Guardian
(if applicable)

____

____

Print Name of Patient

Print Name of Parent or Guardian

Date:_________________________