OKLAHOMA INJURY CARE

James E. Lynch, M.D.
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Carrie Galyon, P.T.
Traci Lambert, APRN
Gary Seymour, APRN
Ron D. Somerville, D.C.

Mailing: PO Box 14740 OKC, OK 73113
N: 200 W. Britton Rd, OKC, OK 73114
Phone: 405-755-8000 Fax: 405-755-8001
S: 7825 S. Walker Ave., OKC, OK 73139
Phone: 405-634-1700 Fax: 405-634-1708

GENERAL INFORMATION

Name: _____ Sex: _____ SS#: _____

Date of Birth: _____ Email Address: _____

Address: _____ Employer Name: _____

Apt. Number: _____ Employer Address: _____

City, State, Zip: _____ City, State, Zip Code: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ May we contact you via email: Yes / No May we contact you via text: Yes / No

Emergency Contact: _____ Phone Number: _____ Relationship: _____

PERSONAL INJURY CLAIM INFORMATION MVA PATIENTS ONLY:

Date of Accident: _____ Name of Insurance Company: _____

Claim Number: _____ Phone Number: _____

Liable Party Name: _____

Is there MEDPAY? Y / N MEDPAY Insurance Company: _____

MEDPAY Claim Number: _____ Phone Number: _____

ASSIGNMENT OF BENEFITS

Please read the following statements very carefully:

If you have insurance, please read and sign below:

I hereby authorize the insurance company reimbursement to be paid by check, made out and directly mailed Advanced Pain Solutions, Inc., DBA: Oklahoma Injury Care (at the address noted on the bill) the medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, any balance of said professional services charges over and above this insurance payment. If my current policy permits payment to be mailed to myself only, I hereby authorize you to list Advanced Pain Solutions, Inc., DBA: Oklahoma Injury Care as the payee on any check issued for services rendered to Advanced Pain Solutions, Inc., DBA: Oklahoma Injury Care. I hereby grant Advanced Pain Solutions, Inc., DBA: Oklahoma Injury Care limited power of attorney for the express purpose of endorsing drafts or checks received by Advanced Pain Solutions, Inc., DBA: Oklahoma Injury Care which are meant as payment for services rendered to me in that office and apply to such funds against my outstanding account(s) in that office.

This is a direct assignment of my rights and benefits for this policy.
A photocopy of this document shall be considered as effective and valid as the original.

SIGNATURE OF CLAIMANT: _____ **DATE**: _____

PATIENT HEALTH INFORMATION

Please check any of the following conditions that apply to you now, or have applied to you in the last six months:

__ Headaches
__ Loss of concentration
__ Light bothers eyes
__ Loss of memory
__ Head seems heavy
__ Dizziness / fainting
__ Ringing in ears
__ Buzzing in ears
__ Visual Problems
__ Loss of balance
__ Jaw pain / TMJ
__ Pneumonia
__ Kidney Disease
__ Bloody / Black Stools
__ Diabetes
__ Pain behind eyes
__ Neck Pain
__ Neck Stiffness
__ Pain with chewing
__ Upper back pain
__ Mid back pain
__ Lower back pain
__ Chest Pain
__ Shortness of breath
__ Asthma
__ Anemia / Bleeding
__ Muscle Weakness
__ Leg swelling / Edema
__ Pins & needles in arms/legs
__ Right / Left arm pain
__ Right / Left leg pain
__ Right / Left shoulder pain
__ Right / Left wrist pain
__ Right / Left elbow pain
__ Right / Left ankle pain
__ Right / Left knee pain
__ Pain in hips
__ Pain in tailbone
__ Mental Disorders
__ Urinary Tract Infection
__ Positive HIV / AIDS
__Seizures
__ Insomnia
__ Irritable
__ Difficulty Breathing
__ Nausea
__ Fatigue
__ Sleep difficulties
__ Sinus trouble
__ Depression
__ Anxiety
__ Hypertension
__ Bronchitis
__ High Blood Pressure
__ Abdominal Pain
__ Hepatitis C
__ Bladder Problems
__ Fever
__ Stomach upset
__ Constipation
__ Diarrhea
__ Menstrual problem
__ Fingers / toes numb
__ Cold hands / feet
__ Arthritis
__ Anemia
__ Tuberculosis
__ Heart Attack
__ Stomach Ulcers

List any other **health conditions** you presently suffer from: _____

_____

Do you routinely take Aspirin, Advil, Motrin, Aleve, Tylenol, Celebrex, or Vioxx? Yes / No If yes, please list: _____

What aggravates these conditions? _____

What decreases the symptoms or pain? _____

Other doctors who treated this condition: Dr._____ Phone: _____

List any **prescription/non-prescription** medicine and vitamins you are taking: _____

_____

List any **drug allergies** you may have: _____

List any **surgical operations** you have had: _____

_____

Date of last physical examination: _____

PERSONAL HABITS:

Do you smoke? Yes / No
If yes, how many packs per day? _____ For how many years? _____

Do you drink alcohol? Yes / No
If yes, do you drink: socially / heavy

Do you use recreational drugs? Yes / No If yes, what types of drugs? _____

Are you (**circle one**): Married Single Divorced Widowed

FAMILY HISTORY (siblings, parents, & grandparents)

High Blood Pressure: No / Yes If yes, who? _____
Heart Attack: No / Yes If yes, who? _____
Diabetes: No / Yes If yes, who? _____
Cancer: No / Yes If yes, who? _____
Stroke: No / Yes If yes, who? _____
Migraines: No / Yes If yes, who? _____
Seizures: No / Yes If yes, who? _____
Bleeding Problems: No / Yes If yes, who? _____

FOR WOMEN ONLY

Are you pregnant? Yes No Unsure If yes, what is your due date? _____

If you are not pregnant, what was your last menstrual period? _____

If there is any possibility of pregnancy, you must inform your doctor prior to any medical treatment. If pregnancy occurs, please notify your doctor prior to treatment. If there is no possibility of pregnancy, please sign and date below, certifying that you are not pregnant.

I hereby certify that I am <u>not</u> pregnant. SIGNED: _____ **DATE**: _____

Other uses and disclosures:
We are permitted and/ or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities, such as required reporting of disease, injury, birth, and death, or required public health investigation;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- Court of administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

- **Access to Your Personal Health Information:** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You are entitled to one free copy of your personal health information. If you request additional copies you may be charged a nominal fee for copying and postage.
- **Amendments to Your Personal Health Information:** You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reason for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.
- **Accounting for Disclosures of Your Personal Health Information:** You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.
- **Restrictions on Use and Disclosure of Your Personal Health Information:** You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agree-to restriction if we believe the termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.
- **Complaints:** If you believe your privacy rights have been violates, you can file a complaint in writing with the Clinic Director/Privacy Officer at Oklahoma Injury Care at PO Box 14740 Oklahoma City, OK 73113. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the Clinic Director/Privacy Officer at Oklahoma Injury Care at 200 W. Britton Rd Oklahoma City, OK 73114.

AUTHORIZATIONS

1. **Authorization to release medical information**
   I hereby authorize the release of medical and medication information pertinent to my care to the Doctors, Nurse Practitioners, Physician Associates, Medical Assistants, and Office Staff at Oklahoma Injury Care.

2. **Privacy notice Acknowledgment**
   With my signature below, I acknowledge that I have read and received a copy of Oklahoma Injury Care Notice of Privacy Practices.

3. **Informed Consent**
   I have been informed that I have the right to refuse any form of treatment. I understand the nature of treatment and have been informed of the risks and possible consequences involved with this treatment.

4. **Financial Responsibility**
   I understand that I am fully responsible to Oklahoma Injury Care for all charges I incur in this office, including deductible, co-pays, co-insurance, and all charges not covered by insurance, as detailed in the Oklahoma Injury Care Financial Policy, available upon request.

5. **Consent to Treat**
   I understand that by signing the authorization below I am allowing for the Doctors, Nurse Practitioners, Physician Associates, Medical Assistants, and Office Staff to treat me and discuss the details of my treatment with me as well as with each other.

I agree to the authorizations listed above and I certify that all the information contained in this booklet is complete and true to the best of my knowledge.

SIGNATURE OF PATIENT: _____ **DATE**: _____

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PAIN INDEX

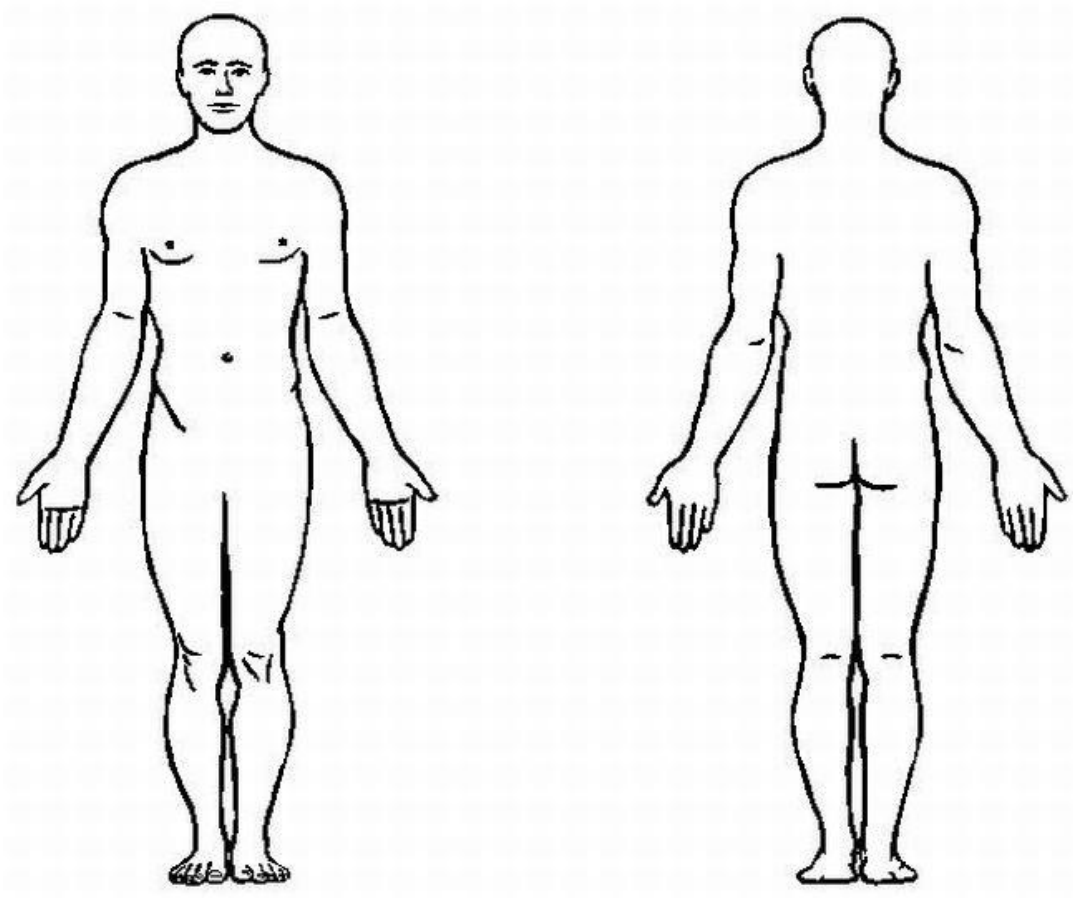
Please list the major complaints you have today:_____

_____

_____

Using the symbols provided below, mark the areas on the illustrations where you are experiencing these sensation:

BURNING	**X**
STABBING	**/**
PINS/NEEDLES	*****
ACHING	**0**
NUMBNESS	**--**



On a scale of 1 to 10, how strong is the pain now? (1 being the least, 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

SIGNATURE OF PATIENT: _____ **DATE**: _____

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Accident Details

Patient name: _____ **DOB:** _____
Date of Accident: _____ Time of Day_____ AM/ PM
Location of Accident: City: _____ State: _____ Zip: _____

What was your position in the vehicle? **Driver** **Front Passenger** **Rear Passenger** **Pedestrian**

Were the vehicle air bags deployed? yes _____ no _____

■What type of vehicle were you driving?

Make: _____ Model: _____ Year: _____

CAR	TRUCK	VAN	SUV
Compact	Small Size	Mini	Compact
Mid Size	Full Size	Full Size	Mid Size
Full Size	Semi	Company	Full Size

■What type of vehicle was the other vehicle?

Make: _____ Model: _____ Year: _____

CAR	TRUCK	VAN	SUV
Compact	Small Size	Mini	Compact
Mid Size	Full Size	Full Size	Mid Size
Full Size	Semi	Company	Full Size

Did you receive medical attention at the scene of the accident? yes _____ no _____
Did you go to the hospital? yes _____ no _____
If yes, what hospital? _____ Were you admitted? yes _____ no _____
Where you taken by: ambulance _____ private transportation _____
Have you been treated for these injuries by another doctor? yes _____ no _____
If yes, what doctor and phone number? _____
Have you been x-rayed since the accident? yes _____ no _____ If yes where: _____
Since the accident has your pain: _____ improved _____ stayed the same _____ worsened

SIGNATURE OF PATIENT: _____ **DATE**: _____

***** Please complete ONLY if you have been seen by another doctor or you have been examined at the emergency room *****

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Release of Medical Records

I hereby authorize _____
(Physician, Hospital, School, Etc.)

_____
(Street Address) (City) (Zip)

To release information from my medical, educational, psychiatric/drug/alcohol records

Specifically:

____ All Records	____ Nursing Notes	____Orders
____ History & Physical	____ Social Serv. Notes	____ Radiology
____ Operative Reports	____ Progress Notes	____ Laboratory
____ Discharge Summary	____ EEG/EKG	____ MRI/ CT Scan

____ Other (Please Specify) _____

From the time period of _____ to _____.

For the following purpose: _____

This information may be released to **Oklahoma Injury Care**
200 W. Britton Rd, Oklahoma City, OK 73114
PLEASE FAX RECORDS TO: 405-755-8001

I understand that the specific type of information to be disclosed may include a history of drug, alcohol, mental health treatment, or communicable disease (IE: AIDS/ HIV/ Hepatitis). I expressly understand and agree that no legal responsibility of any nature shall attach to the attending physician or employee in acting upon this authorization. I understand that I may revoke this content at any time except to the extent that action has been taken in reliance on it and that in any event this content shall expire 90 (ninety) days of patient discharge, unless another date is specified:

(Specification of date or event upon which this consent expires): _____

A photocopy or facsimile of this authorization shall be as effective as an original.

_____ _____
(Date) **(Signature of Patient)**

_____ _____
(Print Patient's Full Name) (Signature of Spouse, Parent, or Guardian)

_____ _____
(Date of Birth) (Relationship)

_____ Male _____ Female

_____
(Witness Signature)

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Permission for Verbal and Written Communication

_____ _____
(Print name of patient) (Birth date)

_____ _____
(Street address) (City, State, Zip Code)

_____
(Phone number)

I permit Oklahoma Injury Care, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to the following medical condition (s):

_____
(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Name	Phone Number	Relationship	Written / Verbal

1. _____

2. _____

Release of information under this document is for verbal discussions and/or written communication with my Health Care Providers. This document does not permit release of any written and/or verbal health information to the individuals named above without being specified.

This authorization is limited to the following timeframe from _____ (date) to _____ (date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions and/or written communications to be permitted between my Health Care Providers and any of the individuals names above, I must notify my Health Care Provider by contacting Oklahoma Injury Care.

SIGNATURE OF PATIENT: _____ **DATE**: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

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Help us help you! Tell us what you expect for care.

Medications

- ☐ **Anti-inflammatory:** Help reduce inflammation, which often helps to relieve pain.
  - *Ibuprofen (Advil, and Motrin IB), Naproxen, Ketorolac (Toradol), and Aspirin.*
- ☐ **Intramuscular Injections:** Help reduce inflammation, which often helps to relieve pain.
  - *Ketorolac (Toradol), Corticosteroids (Kenalog)*
- ☐ **Analgesic:** Relieves pain.
  - *Acetaminophen (Tylenol)*
- ☐ **Muscle relaxant:** Reduces muscle tension and helps relieve muscle pain and discomfort.
  - *Cyclobenzaprine (Flexeril), Methocarbamol (Robaxin), Tizanidine (Zanaflex)*
- ☐ **Narcotic:** Relieves pain, dulls the senses, and causes drowsiness. May become addictive.
  - *Tramadol (Ultram), Hydrocodone, and Oxycodone*

Self-care

- ☐ **Heating pad / Ice pack:** Soothes painful muscles or joints.
- ☐ **Physical exercise:** Can help maintain physical function while recovering.

Therapy

- ☐ **Manual Joint mobilization:** Stretching a joint past its restricted range of motion to restore movement/reduce pain.
- ☐ **Stretching:** Stretching exercises can improve flexibility and improve physical function.
- ☐ **Physical therapy:** Restores muscle strength and function through exercise.
- ☐ **TENS:** Applying a small electrical current to a part of the body to dull the sensation of pain.

Medical Referral

- ☐ **X-RAY:** Tests are commonly done to show up bones and certain other tissues.
- ☐ **CT or CAT:** Combination of X-rays and a computer to create pictures of your organs, bones, and other tissues.
- ☐ **MRI:** Test that uses powerful magnets, radio waves, and a computer to make detailed pictures inside your body.
- ☐ **Epidural steroid injection:** Injection of cortisone and a numbing agent into the spine.

Specialists/Referral

- ☐ **Primary care provider (PCP):** Prevents, diagnoses, and treats diseases.
- ☐ **Orthopedic surgeon:** Performs surgery for conditions affecting bones and muscles.
- ☐ **Spine surgeon:** Performs surgery on the spine.
- ☐ **Pain management:** Eases suffering and improves quality of life for those in pain.