OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

Name: _____ Exam Date: _____

Age: _____ Occupation: _____ Dominant Hand: _____

CHIEF COMPLAINTS

Part (s) of the body injured: _____

HISTORY OF INJURY

Exact date of injury: _____ Day of week: _____

Employer at time of injury: _____

City and State where injury occurred: _____

What were you doing and how did your injury occur? (Please describe in detail): _____

_____

_____

Immediately following the injury what part(s) of your body hurt? _____

_____

Describe the pain and problems following the injury: _____

_____

Did you report the injury to your employer? YES / NO If yes, when: _____

When did you first receive medical treatment for the injury? (date): _____

Name of doctor, clinic, and/or hospital that treated you: _____

_____

Were X-Rays taken? _____ If yes, what part of the body? _____

Any physical therapy? _____If therapy, where? _____

How often did you receive physical therapy? _____ How long? _____

Describe any other treatment given since the injury: (i.e. cast, surgery, TENS unit, etc) _____

_____

Did this help? _____ If yes, describe improvement: _____

_____

Have you seen any other doctors, clinics, hospitals since the injury? _____

Doctor	Specialty	Referred by	City	Date first seen
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Details (special tests, dates of hospitalization, dates of surgery, etc.) _____

_____

_____

_____

Any new injuries or re-injuries since the date of injury? _____

If yes, please describe and give dates: _____

_____

_____

Have you missed any time from work as a result of your injury? _____

If yes, when was the last day you worked? _____ Returned to work? _____

Were you ever told to return to modified duties? _____ If yes, when? _____

Are you currently working? _____ Same company? _____

PRESENT COMPLAINTS: (describe in detail)

_____

_____

_____

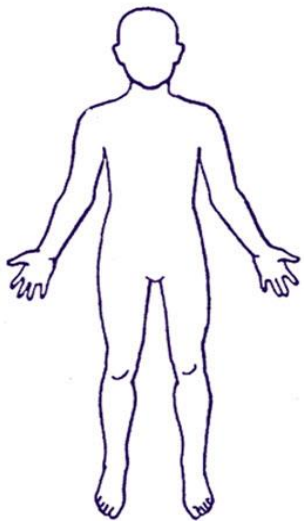
_____

_____

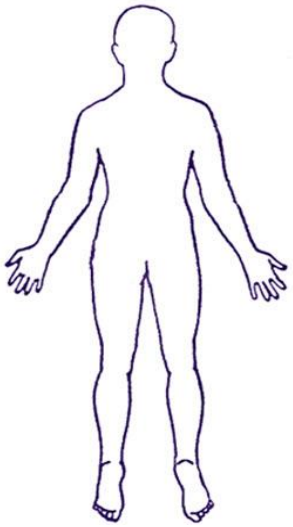
_____

Indicate with the following symbols what kind of pain and where it is located:

Sharp pain - xxxxx Dull pain - ooooo Numbness or tingling – use shading

Right  Left

Front

Right  Left

Back

Does the pain travel? YES / NO

If yes, describe where it travels: _____

_____

What makes pain worse? _____

What makes pain better? _____

Where does it hurt the most? _____

Describe your pain: DULL SHARP ACHING STABBING THROBBING BURNING

Other: _____

On a scale of 1 to 10, 10 being the worse, Rate your pain 0 1 2 3 4 5 6 7 8 9 10

PRESENT TREATMENT:

Are you still treating with the first physician who saw you for your injury? _____

If no, name of current treating physician: _____

Type of treatment you are receiving: _____

Date of last visit with current treating physician: _____

Date of last treatment (i.e. injection, physical therapy, medication)_____

OCCUPATIONAL HISTORY

Job title	Employer	From (month/year) to (month/year)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

JOB DESCRIPTION

When the injury occurred how many hours did you work in a day? _____ Week _____ Overtime_____

Occupation at time of injury: _____

List of job duties and physical requirements of your work at the time of injury: _____

_____

_____

_____

Work activities performed: Mark your usual work duties (at the time of injury) with the following letters:
N = Not at all O = Occasionally F = Frequently C = Constantly 3

_____ Stand	_____Kneel	_____Reach	_____Overhead work
_____Walk	_____Stoop	_____Twist	_____a. 10lbs or less
_____Climb	_____Push	_____Drive vehicle	_____b. 11 to 25 lbs
_____Squat	_____Pull	_____Detailed hand work	_____c. 26 to 50 lbs
_____Lift	_____Bend		_____d. 51 to 75 lbs
			_____e. 76 to 100 lbs
			_____f. over 100 lbs
			_____ With assistance?

Total years performed this type of work? _____Total years worked for employer at time of injury? _____

Work activities performed on present occupation (if different than above) Mark your usual work duties with the following letters: N = Not at all O = Occasionally F = Frequently C = Constantly 3

_____ Stand	_____Kneel	_____Reach	_____Overhead work
_____Walk	_____Stoop	_____Twist	_____a. 10lbs or less
_____Climb	_____Push	_____Drive vehicle	_____b. 11 to 25 lbs
_____Squat	_____Pull	_____Detailed hand work	_____c. 26 to 50 lbs
_____Lift	_____Bend		_____d. 51 to 75 lbs
			_____e. 76 to 100 lbs
			_____f. over 100 lbs
			_____ With assistance?

Other: _____Total number of years at this type of work: _____

PAST MEDICAL HISTORY

Have you had previous injuries or treatment to any parts of the body of which you are being seen for today? YES / NO

If yes, please give dates and types of treatment. Please include sports injuries or motor vehicle accident etc _____

_____

_____

_____

_____

Any other work related injuries not described above? _____

_____

Did you recover from above injuries? _____ if no, please explain: _____

_____

I certify that the above information is true and correct to the best of my knowledge. I understand it is important and necessary to give correct information for a proper medical evaluation.

_____ _____

Patient's Signature Date

Oklahoma Sports Science & Orthopedics

Shehan Abeyewardene, MD
10001 S. Western Ave., Suite 101 • OKC, OK 73139
Phone (405) 692-3700 • Fax (405) 692-3783

NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

FIRST NAME	MIDDLE NAME	LAST NAME	DOB	SSN	SEX

ADDRESS:	CITY:	STATE:	ZIP CODE:

HOME PHONE: ( )	WORK PHONE: ( )	MOBILE PHONE: ( )

EMAIL ADDRESS	MARITAL STATUS:	MOTHER'S MAIDEN NAME (IF MINOR):	DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO

PREFERRED LANGUAGE:	WRITTEN LANGUAGE:	RACE:	ETHNICITY:	RELIGION:

NEXT-OF-KIN INFORMATION

EMERGENCY CONTACT	RELATIONSHIP	PRIMARY PHONE: ( )	PREFERRED LANGUAGE	☐ LEGAL GUARDIAN?

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS ☐ Disabled ☐ Full-time ☐ Not Employed ☐ Active Military ☐ Part-Time ☐ Self-Employed ☐ Student ☐ Retired ☐ Unknown

EMPLOYER:	ADDRESS	CITY / STATE	ZIP CODE:

APPOINTMENT INFORMATION

REFERRING PROVIDER:	IS THIS VISIT ACCIDENT RELATED? ☐ Yes ☐ No	DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ Yes ☐ No

GUARANTOR INFORMATION (PLEASE COMPLETE, IF GURANTOR IS NOT PATIENT/MINOR)

RELATIONSHIP TO PATIENT	NAME:	DOB:	SEX:	SSN:

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

PRIMARY COVERAGE:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DOB	SUBSCRIBER'S SSN:

SUBSCRIBER'S ID:	PATIENT'S ID (IF DIFFERENT):	GROUP NUMBER:

SUBSCRIBER'S ADDRESS:	CITY	STATE	ZIP CODE

SUBSCRIBER'S EMPLOYMENT STATUS:	SUBSCRIBER'S EMPLOYER NAME:	EMPLOYER'S ADDRESS:

SECONDARY COVERAGE:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DOB	SUBSCRIBER'S SSN:

SUBSCRIBER'S ID:	PATIENT'S ID (IF DIFFERENT):	GROUP NUMBER:

SUBSCRIBER'S ADDRESS:	CITY	STATE	SUBSCRIBER'S ADDRESS:

SUBSCRIBER'S EMPLOYMENT STATUS:	SUBSCRIBER'S EMPLOYER NAME:	EMPLOYER'S ADDRESS:

Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I acknowledge and agree that I have received a copy of the TPG Privacy Notice.

SIGNATURE: _____ DATE: _____

Shehan Abeyewardene, MD
10001 S. Western Ave., Suite 101 • OKC, OK 73139
Phone (405) 692-3700 • Fax (405) 692-3783

Name: _____ DOB:_____ MR#:_____
Age: _____ Height: _____ Weight: _____ BP: _____ Pulse: _____ Resp: _____
Referring Physician Name and Phone Number:_____
Have you ever seen a Cardiologist? YES/NO If yes, who:_____
Reason for Today's visit:_____
Injury? YES/NO Date of Injury? _____ Work related? YES/NO Auto Accident? YES/NO
Brief Description of Injury:_____
_____

MEDICATIONS: list all of the prescription and over the counter medications you are currently taking.

☐ I AM CURRENTLY NOT TAKING ANY MEDICATIONS

Medication Name	Dosage	Frequency

PHARMACY: List the name and location of your preferred pharmacy. Please note we do not use Walmart pharmacies, this includes Sam's Club and Neighborhood Walmart.

Pharmacy:_____ Location/Phone #:_____

ALLERGIES:

☐ I HAVE NO KNOWN ALLERGIES

Allergies	Describe Reaction (e.g., hives, rash, itching, nausea, diarrhea, headaches, fainting, shortness of breath, etc.)

Patient Signature: _____ Date:_____

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Past Medical History

Cardiovascular:

- ☐ Arrhythmia
- ☐ Chest Pain
- ☐ CHF
- ☐ Coronary artery disease
- ☐ Deep vein thrombosis
- ☐ Heart murmur
- ☐ Hypertension
- ☐ Myocardial infarction
- ☐ PVD

Endocrine:

- ☐ Diabetes mellitus
- ☐ Kidney disease
- ☐ Thyroid disease

Gastrointestinal:

- ☐ GERD
- ☐ Obesity

Hematologic

- ☐ Anemia
- ☐ High Cholesterol

Infection

- ☐ Clostridium Difficule
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ STD
- ☐ Tuberculosis
- ☐ VRE

Musculoskeletal:

- ☐ Arthritis
- ☐ Fractures
- ☐ Rheumatoid arthritis

Neurological:

- ☐ Dementia
- ☐ Seizure
- ☐ Stroke

Pulmonary:

- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ COPD
- ☐ Home Oxygen Use
- ☐ Pneumonia
- ☐ Pulmonary arterial HTN
- ☐ Pulmonary embolism
- ☐ Sleep apnea

Additional Pertinent Medical HX:

- ☐ Blood transfusion
- ☐ Cancer
- ☐ Insomnia

Behavioral Health:

- ☐ ADD/ADHD
- ☐ Alcohol abuse
- ☐ Alcoholism
- ☐ Anorexia nervosa
- ☐ Anxiety
- ☐ Autism spectrum disorder
- ☐ Bipolar disorder
- ☐ Borderline personality
- ☐ Bullimia nervosa
- ☐ Depression
- ☐ Head injury
- ☐ History of violence
- ☐ OCD
- ☐ ODD
- ☐ Panic disorder
- ☐ Psychiatric illness
- ☐ Psychosis
- ☐ PTSD
- ☐ Schizoaffective disorder
- ☐ Self-injurious behavior
- ☐ Substance abuse
- ☐ Suicide attempts
- ☐ Withdrawal symptoms (alcohol)
- ☐ Withdrawal symptoms (drug)

Anesthesia History

- ☐ Abnormal ECG
- ☐ Clotting disorder
- ☐ Difficult Intubation
- ☐ Fatigue
- ☐ Malignant hyperthermia
- ☐ Motion sickness
- ☐ PONV
- ☐ Spinal headache

Other Medial History: _____

Social History

Please circle your answer

Tobacco:

Smoking: Never Former Every Day Some Days Cessation Comments: _____

Smokeless: Never Former Every Day Some Days _____

Alcohol Use: Yes No Defer Drinks per week: _____

Drug Use: Yes Never Not Currently Defer Comments: _____

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Past Surgical History

Please check or list all of the SURGERIES you have had

- ☐ Abdomen surgery
- ☐ Amputation
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cardiac catheterization
- ☐ Cholecystectomy (Gallbladder)
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ C-Section
- ☐ Dilatation and Curettage
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Gastrectomy
- ☐ Heart surgery
- ☐ Heart transplant
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Kidney transplant
- ☐ Lithotripsy
- ☐ Liver transplant
- ☐ Lung transplant
- ☐ Mastectomy
- ☐ Neck surgery
- ☐ Pacemaker insertion
- ☐ Skin biopsy
- ☐ Tubal ligation
- ☐ Vascular surgery
- ☐ Weight loss surgery

Other surgeries not listed: _____

_____

_____

Family History

Have any of your family members had any of the following problems?

Relationship	No Known Problems	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug abuse	Early Death	Hearing Loss	Hyperlipidemia	Hypertension	Kidney disease	Learning disabilities	Mental illness	Mental retardation	Miscarriages/Stillborn	Stroke	Suicide Attempts	Vision loss	Other Medical History
Father																							
Mother																							
Sister																							
Brother																							
M. Grandmother																							
M. Grandfather																							
P. Grandmother																							
P. Grandfather																							
Other Relative: _____																							

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Review of Systems

Are you experiencing any of the following symptoms?

Constitutional:
- ☐ appetite loss
- ☐ chills
- ☐ diaphoresis
- ☐ fever
- ☐ malaise/fatigue
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss

HENT:
- ☐ congestion
- ☐ ear discharge
- ☐ ear pain
- ☐ hearing loss
- ☐ hoarseness
- ☐ odynophagia
- ☐ sore throat
- ☐ stridor
- ☐ tinnitus

GI:
- ☐ abdominal bloating
- ☐ abdominal pain
- ☐ anorexia
- ☐ bowel habits change
- ☐ bowel incontinence
- ☐ constipation
- ☐ diarrhea
- ☐ dysphagia
- ☐ excessive appetite
- ☐ flatus
- ☐ heartburn
- ☐ hematemesis
- ☐ hematochezia
- ☐ jaundice
- ☐ melena
- ☐ nausea
- ☐ vomiting

Eyes:
- ☐ blurred vision
- ☐ discharge
- ☐ double vision
- ☐ pain
- ☐ photophobia
- ☐ redness
- ☐ vision loss – left
- ☐ vision loss – right
- ☐ visual disturbance
- ☐ visual halos

Cardiology:
- ☐ chest pain
- ☐ claudication
- ☐ cyanosis
- ☐ dyspnea on exertion
- ☐ irregular heartbeats
- ☐ leg swelling
- ☐ near-syncope
- ☐ orthopnea
- ☐ palpitations
- ☐ PND
- ☐ syncope

GU:
- ☐ bladder incontinence
- ☐ decreased libido
- ☐ dysuria
- ☐ flank pain
- ☐ frequency
- ☐ genital sore
- ☐ hematuria
- ☐ hesitancy
- ☐ incomplete emptying
- ☐ menorrhagia
- ☐ missed menses
- ☐ nocturia
- ☐ non-menstrual bleeding
- ☐ pelvic pain
- ☐ urgency

Respiratory:
- ☐ cough
- ☐ hemoptysis
- ☐ shortness of breath
- ☐ sleep disturbances due to breathing
- ☐ snoring
- ☐ sputum production
- ☐ wheezing

Endocrine:
- ☐ intolerance of cold
- ☐ intolerance of heat
- ☐ polydipsia
- ☐ polyuria

Heme/Lymph:
- ☐ adenopathy
- ☐ bleeding
- ☐ easy bruising/bleeding

Neurological:
- ☐ aphonia
- ☐ brief paralysis
- ☐ concentration difficulty
- ☐ coordination disturbances
- ☐ daytime sleepiness
- ☐ dizziness
- ☐ focal weakness
- ☐ generalized weakness
- ☐ headaches
- ☐ light-headedness
- ☐ loss of balance
- ☐ numbness
- ☐ paresthesia
- ☐ seizures
- ☐ sensory change
- ☐ tremors
- ☐ vertigo

Skin:
- ☐ changes in nail beds
- ☐ discoloration
- ☐ dryness
- ☐ flushing
- ☐ itching
- ☐ poor wound healing
- ☐ rash
- ☐ skin cancer
- ☐ suspicious lesions
- ☐ unusual hair distribution

Musculoskeletal:
- ☐ arthritis
- ☐ back pain
- ☐ falls
- ☐ gout
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle cramps
- ☐ muscle weakness
- ☐ myalgia
- ☐ neck pain
- ☐ stiffness

Psychiatric:
- ☐ altered mental status
- ☐ depression
- ☐ hallucinations
- ☐ hypervigilance
- ☐ insomnia
- ☐ memory loss
- ☐ nervous/anxious
- ☐ substance abuse
- ☐ suicidal ideas
- ☐ thoughts of violence

Allergy/Immuno:
- ☐ environmental Allergies
- ☐ HIV exposure
- ☐ hives
- ☐ persistent infections

OKLAHOMA SPORTS SCIENCE AND ORTHOPEDICS

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ DOB:_____

I hereby authorize confidential communications from the physicians or staff of OSSO regarding my health, care treatments, appointments, prescriptions etc. to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, 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: _____

I understand this authorization will remain in effect for one year or unless I revoke the authorization in writing.

Patient Signature: _____ Date: _____

OSSO STAFF ONLY:
Documented by:

_____ _____
Initials Date

OKLAHOMA SPORTS SCIENCE AND ORTHOPEDICS

FINANCIAL POLICY

Thank you for choosing Oklahoma Sport Science & Orthopedics as your healthcare provider. At OSSO we are dedicated to providing the highest quality, most cost effective care. We specialize in Adult and Pediatric Orthopedics, Sports Medicine, Physical Medicine and Rehabilitation, Pain Management, Reconstructive and Orthopedics Spine Surgery and Hand Surgery.

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 provider's 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 with all referral, pre-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.

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 Card, American Express or MasterCard. In most cases we can arrange payment plans for patients who have financial concerns. Please notify our office at 692-3700 to make payment arrangements. **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.**

If your injury was due to a motor vehicle accident, unless other arrangements have been made, you may be set up 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 a third party in order to ensure payment to the physician. **Please note that not all OSSO Physicians will accept third party/ MVA patients.**

There is a $40 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or any other invasive procedures that are scheduled at Community Hospital, Northwest Surgical Hospital or Community Hospital North, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

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

Sincerely,
OSSO Physicians and Staff
My signature below acknowledges receipts of this Financial Policy:

Signature: _____ Date: _____

Relationship if other than patient:
_____

OKLAHOMA SPORTS SCIENCE AND ORTHOPEDICS

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & 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 Oklahoma Sports Science & 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 Oklahoma Sports Science & Orthopedics charge or who may be responsible in 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, 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 release all of the information in my medical records, including any information concerning identity, and release Oklahoma Sports Science & Orthopedics, its agents and 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 to Oklahoma Sports Science and Orthopedics. I understand that I am financially responsible for charges not covered by this assignment.

I 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 a 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 Science and Orthopedics from any claim for responsibility or damages in the event of loss of my personal property, including, but not limited to, money and jewelry.

I understand a photocopy of this document is as valid as the original.

Patient Signature: _____ Date: _____

Responsible Party: _____ Relation to Patient: _____

Insurance Policyholder's Signature: _____

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 of exposures, release risk of exposures, release pursuant to an order of the court of the Department 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 the order of the court, or the department of health, or by law.

OKLAHOMA SPORTS SCIENCE AND ORTHOPEDICS

DR. SHEHAN ABEYEWARDENE

PAIN CONTRACT

- The pain you are experiencing may be improved, but not eliminated with use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be filled if you don't keep these appointments.
- Pain medication is filled only for post-operative patients and not filled indefinitely. If pain medications are needed beyond this period you will be referred to long term pain management.
- Your treating physician is the only physician who should prescribe narcotic pain medication to you.
- It is your responsibility to notify us of any other Physicians who are prescribing narcotic pain medications to you. It is also your responsibility to inform other physicians that we are prescribing you narcotic pain medications.
- Any "Drug Seeking Behavior" will not be tolerated and will result in your dismissal as a patient and possible reporting to the police, DEA, or FDA. Drug seeking behavior includes, but is not limited to: excessive calls requesting increase in the does or frequency of pain medication, refills before they are due, and doctor shopping. Dispensing your medication to others for their use or for money will result in the same consequences.
- Pain medication refill request are taken **Monday through Thursday from 8:30 a.m. to 3:30 p.m. only. Prescription refills are not taken or called in on Friday, Saturday, Sunday, holidays or after hours for any reason.** We guarantee prescription refills will be processed within 72 hours of the request.
- Lost, stolen or misplaced medications **are never replaced - no exceptions.** Your medication is your responsibility.
- Narcotic pain medication has many side effects. Overuse could lead to breathing difficulties and even death. Heavy machinery should never be used while taking pain medication. Make sure you are educated on the possible side effects of your medication by your pharmacist. If you have any concerns please contact our office.

Informed consent: I _____ have been informed and clearly understand the above-listed issues regarding the treatment of pain with narcotic pain medication. I understand that this agreement will be filed in my chart as part of my permanent medical record.

Signature: _____ Date: _____

OKLAHOMA SPORTS SCIENCE AND ORTHOPEDICS

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Shehan Abeyewardene has an ownership interest in Community Hospital and Northwest Surgical Hospital.

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 Community Hospital or Northwest Surgical Hospital. 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 Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.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 Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Date_____

Oklahoma Sports Science & Orthopedics

Shehan Abeyewardene, MD
10001 S. Western Ave., Suite 101 • OKC, OK 73139
Phone (405) 692-3700 • Fax (405) 692-3783

APPOINTMENT NO SHOW AND LATE POLICY

APPOINTMENT NO SHOWS

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to a scheduled appointment. We will hold your scheduled appointment time for 20 minutes. If you have not shown up within 20 minutes of your scheduled appointment time it will be a no show appointment.

A no show appointment will result in a $25.00 charge to the patient, not your insurance company. This must be paid prior to scheduling your next appointment.

LATE POLICY

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day.

Patients arriving early or on time will be seen in the order they were scheduled.

Any patient arriving more than 20 minutes late will be asked to reschedule.

_____ _____

Signature of Patient

Signature of Parent or Guardian
(if applicable)

_____ _____

Print Name of Patient

Print Name of Parent or Guardian

Date_____

SURGERY OPIOID CONSENT FORM

Patient Name:	**Date of Birth:**
The doctor may prescribe Opioids to control and manage post-surgical pain.	
Alternative options to opioids are Over the counter pain medications such as Tylenol, Advil, Excedrin.	

Instructions: *Please review the information listed below and put your initials next to each item when you feel you understand and accept what each statement says.*

	Initials
My surgeon will prescribe an opioid medication to help me control and manage post-surgical pain.	
This medicine is used to decrease and manage my pain but will not take away my pain completely.	
I will stop using the opioid medicine as soon as my pain is manageable and will use over the counter pain relievers if possible to manage the pain.	
I will contact my provider if the medicine does not control my pain when I take it as prescribed or if I have any adverse reactions to it.	
I will follow-up with my provider for post-surgical consultations as instructed or requested by my provider.	
If I do not use all of the medicine prescribed, I will ensure that it is disposed of properly in order to prevent its misuse by someone else.	
I will safely store the medicine to minimize the risk that children or other people will take it.	
When I take this medicine it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.	
When I take this medication, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.	
I may become physically or psychologically dependent or addicted to this medicine if I take them continuously so I agree to stop using them at the earliest possible time and to take no more than is necessary to control my pain.	
I have told my provider if I or anyone in my family has had any problems with mental illness or with controlling drug or alcohol use in the past.	
Taking too much of my pain medication, or mixing my pain medications with drugs, alcohol, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.	
It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.	
I will not use any illegal substance, such as cocaine, etc., while taking this medicine.	
If I travel out of the country while taking this medicine, I will notify the appropriate travel authority (usually the consulate website of the country) and obtain a note from my provider before travel, as traveling out of country with opioids may pose problems.	
For females: I understand it is my responsibility to inform my provider if I am pregnant.	

Signature of patient or guardian	**Date**
Printed name of patient or guardian:	