OCO
OKLAHOMA CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

RITA M. HANCOCK, M.D.
PHYSICAL MEDICINE AND REHABILITATION | NON-NARCOTIC PAIN MANAGEMENT

Thank Dear Future Patient,

you for choosing us to help you with your healthcare needs!

In order to SPEED UP the process of getting you an appointment, we require that you read and agree to our **no-show and late cancellation policy** (see attached).

Unfortunately, certain patients no-show or cancel or reschedule so close to their appointment time that we cannot put *patients like you*, who may be waiting for an appointment, in their spot.

Therefore, in order to better serve patients who are waiting (in pain) to see the doctor, please understand that we will ask you to agree to the following policies BEFORE you are given your first appointment.

- **You (not your insurance company) will be charged $50** if you fail to keep your appointment ("no-show") or if you fail to give us a FULL 24 hours notice before cancelling or rescheduling.

- **You will not be given a second appointment** if you fail to give us a FULL 24 HOURS notice prior to cancelling or rescheduling.

- **You will not be given a second appointment** if you no-show for your intake evaluation with Dr. Hancock.

Please understand that our goal is to create space in the schedule so we can better serve you (and others who hurt) as soon as possible.

Sincerely,

Dr. Hancock and Staff.

3110 SW 89TH STREET, SUITE 200C | OKLAHOMA CITY, OK 73159
PHONE 405-759-2663 | FAX 405-703-4866
WWW.OCOSPORTS.COM

Dr. Hancock No-Show and/or Late Cancellation/Reschedule Policy*

**Note that Dr. Rita Hancock charges a Fee For Late Cancellations & No-shows*

For new patients:

- You (not your insurance company) will be charged ***$50*** if you fail to keep your appointment ("no-show") or if you fail to give us a FULL 24 hours notice before cancelling or rescheduling.

- You will not be given a second appointment if you fail to give us a FULL 24 HOURS notice prior to cancelling or rescheduling.

- You will not be given a second appointment if you no-show for your intake evaluation with Dr. Hancock.

For established patients:

- You (not your insurance company) will be charged ***$25*** if you fail to keep your appointment ("no-show") or if you fail to give us a FULL 24 hours notice before cancelling or rescheduling.

- You will not be given an additional appointment if you refuse to pay the $25.

- You may be discharged from the practice if you no-show or reschedule late a second time or if you refuse to pay the no-show or late cancellation fees.

Thank you for understanding that we need to optimize our efficiency in seeing patients in order to give you the appointments that you need when you need them.

I _____(PRINTED PATIENT NAME)) hereby agree to this policy and will keep scheduled appointments with Dr. Hancock.

_____(SIGNATURE)_____(DATE)

OKLAHOMA CENTER FOR ORTHOPAEDIC & SPORTS MEDICINE

PLEASE PRINT

M. Sean O'Brien, D.O. | Rory C. Dunham, D.O. | Rita M. Hancock, M.D.

PATIENT INFORMATION

Date	Referring Physician	Referring Physician Phone

Last	First	Middle	Sex
			❑ M ❑ F

Address	City	State	Zip

Home Telephone ( )	Age	Birthdate / /	Marital Status S M W D DEP	SS# — —

Employer/School	Address	City	State	Zip

Work Phone & Ext. ( )	Cell Phone	Pager	E-Mail

Patient's Nearest Relative (Other than Spouse)	Relation	Home Phone ( )	Work Phone & Ext. ( )

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient	Home Telephone ( )

Address	City	State	Zip

Employer	SS# — —	Birthdate / /	Age	Work Phone & Ext. ( )

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance	Insurance Type ❑ Group ❑ Individual ❑ Cobra

Address	City	State	Zip

Insured's Name on Card	I.D. #	Group #

Insured's Birthdate / /	Patient Relation to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other	Insured's Sex ❑ M ❑ F	Insured's SS# — —

Insured's Employer	Telephone & Ext. ( )

Secondary Insurance	Insurance Type ❑ Group ❑ Individual ❑ Cobra

Address	City	State	Zip

Insured's Name on Card	I.D. #	Group #

Insured's Birthdate / /	Patient Relation to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other	Insured's Sex ❑ M ❑ F	Insured's SS# — —

Insured's Employer	Telephone & Ext. ( )

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Oklahoma Center for Orthopaedic & Sports Medicine. I understand I am financially responsible for any charge not covered by my insurance.

PATIENT OR AUTHORIZED PERSON

DATE

Reorder From BMSI (405) 685-0177 • OKC266- Form # R-0003 (Rev. 10/14)

Oklahoma C er for
Orthopaedics & Sports Medicine
3110 S.W. 89th, Suite 200C
Oklahoma City, OK 73159
Fax (405) 703-4866

Rita Hancock, M.D.
Telephone (405) 759-2663

NEW PATIENT QUESTIONNAIRE

NAME: _____ **AGE:** _____ **DOB:** _____ **M / F** **Date:** _____

OCCUPATION: _____ **HEIGHT:** _____ **WEIGHT:** _____

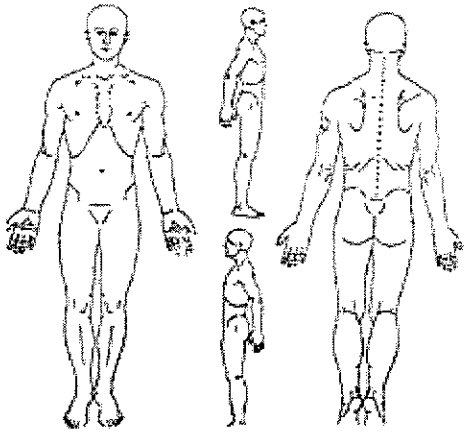
LANGUAGE: _____ **RACE/ETHNICITY:** _____

REFERRED BY: _____ **FAMILY DOCTOR:** _____

WHAT IS THE MAIN PROBLEM/ISSUE THAT YOU ARE HERE TO ADDRESS?

_____

INDICATE ON THE DIAGRAM WHERE YOU HAVE SYMPTOMS
Use letters to show where you have symptoms: P=pain; N=numbness; T=tingling; B=burning; O=other (explain "other"). Use arrows and write extra information if you wish.



ON A SCALE OF 1-10, HOW BAD IS IT? ("10" means VERY SEVERE): _____

WHEN DID THE VERY FIRST EPISODE OCCUR? _____

IF THIS IS AN ON-AND-OFF PROBLEM, WHEN DID THE LATEST EPISODE START?

_____

WHAT OTHER DOCTORS HAVE YOU SEEN FOR THIS PROBLEM? _____

_____

WHAT TREATMENTS HAVE HELPED? _____

WHAT TREATMENTS DID NOT HELP? _____

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PATIENT NAME:_____ **DOB:**_____
WAS THERE AN INJURY? Y / N WHAT HAPPENED? _____
_____
DATE OF INJURY: _____
IF THERE WAS AN INJURY, WAS IT:

- WORK-RELATED? **Y / N** IF YES, EXACT DATE OF THE INJURY: _____
- PERSONAL INJURY? **Y / N**
- CAUSED BY A MOTOR VEHICLE ACCIDENT? **Y / N**
- OTHER PERSONAL INJURY? **Y / N** IF YES, WHAT KIND: _____
- ARE YOU REPRESENTED BY AN ATTORNEY FOR IT ? **Y / N**
  IF YES, LIST THE ATTORNEY'S NAME AND CONTACT INFO _____

_____

CIRCLE THE OTHER SYMPTOMS THAT ACCOMPANY YOUR PROBLEM

General: Fever; Weight Loss; Weight Gain; Night Sweats; Other:_____
Eyes: Blurred Vision; Double Vision; Eye Pain; Dry Eyes; Other:_____
Ears/Nose/Throat: Sinus Problems; Trouble Swallowing; Other:_____
Heart: Chest Pain; Irregular Heartbeat; Heart Attacks; Other:_____
Lung: Trouble Breathing; Sputum Production; On Oxygen; Other:_____
Bladder: Frequent Infections; Trouble Holding Urine; Other:_____
Bowel: Constipation; Diarrhea; Cramps; Bloating; Loss of Control; Other:_____
Muscle: Spasm; Twitching; Cramps; Weakness; Other:_____
Nerves: Numbness; Tingling; Pain; Weakness; Burning; Headaches; Memory Loss; Lack of Coordination; Dizziness/Vertigo; Falling; Tremors; Other:_____
Skin/Extremities: Dry Skin; Swelling; Blueness of fingers/toes; Other:_____
Psychological: Depression; Anxiety; Panic; Sleep Problems; Hearing Voices; Alcohol Abuse; Substance Abuse; "Seeing Things;" Other:_____
Hormones: Hair Loss; Lump in Throat; Nipple Discharge; Other:_____
Immune System: Frequent Infections; Severe Allergies (Anaphylaxis); Other:_____

PAST MEDICAL HISTORY? (CIRCLE)

NO KNOWN MEDICAL PROBLEMS	DIABETES	MIGRAINES	OTHER: _____
HIGH BLOOD PRESSURE	OBESITY	KIDNEY STONES	OTHER: _____
THYROID DISEASE	ASTHMA	ANEMIA	OTHER: _____
HEART ATTACK/HEART DISEASE	SEIZURES	ARTHRITIS	OTHER: _____
HEART ARRYTHMIA	STROKE	IBS	
SPINE/JOINT PAIN	DEPRESSION	ANXIETY	
DRUG ADDICTION	SUBSTANCE ABUSE		
ALCOHOL ABUSE			

CANCER (WHAT KIND? _____ AND WHEN? _____)

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PATIENT NAME:_____ **DOB:**_____

PAST SURGICAL HISTORY? (CIRCLE)

NONE	HYSTERECTOMY	FRACTURE REPAIR: _____
HERNIA	OPEN HEART/CABG	JOINT SCOPE/REPLACEMENT:_____
PROSTATE	NECK OR BACK	OTHER: _____
TONSILS	CATARACTS	OTHER: _____
APPENDIX	GALLBLADDER	OTHER: _____

FAMILY HISTORY OF ILLNESS:
In the blank spaces, list family members who have these disorders:
(Please indicated which family member. i.e. parent(s), grandparent(s), sibling, etc.)

HEART DISEASE _____ HIGH BLOOD PRESSURE _____ STROKE _____
DIABETES _____ THYROID _____ BLEEDING DISORDER _____
MENTAL ILLNESS OR ADDICTION (TYPE?)_____ (WHO?) _____
AUTOIMMUNE, RHEUMATOID, LUPUS, ETC. (TYPE?)_____ (WHO?)_____
SPINE, JOINT, OR NERVE PROBLEMS (TYPE?)_____ (WHO?)_____
CANCER (TYPE?)_____ (WHO?)_____
CANCER (TYPE?)_____ (WHO?)_____
OTHER DISORDER (TYPE?)_____ (WHO?)_____

SOCIAL HISTORY:

SINGLE	MARRIED	WIDOWED	DIVORCED
DO YOU DRINK ALCOHOL? Y / N		IF YES, _____# DRINKS/WEEK	
DO YOU USE TOBACCO PRODUCTS? Y / N		IF YES, _____# PACKS/DAY	

DRUG ALLERGIES?

NO KNOWN	MORPHINE
PENCILLIN	ERYTRHOMYCIN
LATEX	ADHESIVE TAPE
IODINE	OTHER: _____
SULFA	OTHER: _____
CODEINE	OTHER: _____

IS THERE ANY CHANCE YOU'RE PREGNANT? (NOTIFY BOTH THE NURSE AND THE DOCTOR VERBALLY IF THIS IS THE CASE!)

IMAGING STUDIES: REGARDING THE PROBLEM YOU CAME IN FOR TODAY, WHAT TESTS HAVE BEEN DONE?
(CIRCLE): X-RAYS CT SCAN MRI EMG BONE SCAN
BONE DENSITY TESTING BLOOD-WORK OTHER_____

AT WHAT FACILITIES? _____ **WHEN?** _____
ORDERED BY WHICH PHYSICIAN? _____

WHAT MEDCINES DO YOU TAKE CURRENTLY (WITH DOSES AND FREQUENCY)?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

M. Sean O'Brien, D.O. | Rory C. Dunham, D.O. | Rita M. Hancock, M.D.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____ acknowledge that I have received a copy of
(Patient Name)

Oklahoma Center for Orthopaedic Excellence & Sports Medicine's Notice of Privacy Practices. This Notice describes how Oklahoma Center for Orthopaedic Excellence & Sports Medicine may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of Patient, or Personal Representative Date

_____
Relation to Patient

ACCESS TO MEDICAL RECORDS

The person or persons listed below may have access to my medical records.

_____ _____
Name Relation to Patient

_____ _____
Name Relation to Patient

CONSENT TO DISCUSS DIAGNOSIS AND TREATMENT WITH ATHLETIC TRAINER

☐ I authorize OCO to discuss my diagnosis and treatment with my school's athletic training staff.

I have read each of the above paragraphs and fully agree to each of the statements.
I acknowledge my agreement by signing below.

_____ _____
Patient Date

_____ _____
Parent or Guardian Date
(if patient is under 18 years of age)

PHARMACY INFORMATION

Please provide us with your preferred pharmacy information. We will only refill prescriptions to the pharmacy we have on file for you.

Pharmacy: _____

Address: _____

Phone: _____

<u>All questions must be filled in. Please do not leave blank.</u>

I _____ **understand that I can only use one pharmacy for prescriptions to be called in from this office.**

Signature _____

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. M. Sean O'Brien, D.O. and Rory C. Dunham, D.O. each have an ownership interest in Community Hospital and Northwest Surgical Hospital. SSM Health Care of Oklahoma d/b/a St. Anthony Hospital is also a proud affiliate of 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

Dated:_____

Community Hospital at Fountain Park
Community Hospital OUTPATIENT THERAPY
Community Hospital at St. Anthony North
Northwest Surgical Hospital
LakePointe IMAGING CENTER Northwest Surgical Hospital