**Oklahoma Center for Orthopaedics & Sports Medicine**
3110 S.W. 89th, Suite 200C
Oklahoma City, OK 73159
Fax (405) 759-3827

**M. Sean O'Brien, D.O.**
Telephone (405) 759-2663

**Rory C. Dunham, D.O.**
Telephone (405) 759-2562

## NEW PATIENT QUESTIONNAIRE

DATE:

| | | | |
|---|---|---|---|
| NAME: | | PHONE: | |
| AGE: | SEX: | HEIGHT: | WEIGHT: |
| RACE/ETHNICITY: | | LANGUAGE: | |
| FAMILY PHYSICIAN: | | REFERRED BY: | |
| **REASON FOR VISIT:** | | **IS THIS INJURY WORK RELATED?** ☐**YES** ☐**NO** | |
| R/L/BIL | | OCCUPATION: | |

**DATE OF ONSET/INJURY**(INSURANCE REQUIRES APPROX. DATE) **MO.**_____ **DAY**_____ **YEAR**_____

| **HAND DOMINANCE** | **CURRENT LEVEL OF FUNCTION** | **CURRENT LEVEL OF PAIN** |
|---|---|---|
| RIGHT / LEFT | 0-100 (0 BEING WORST) _____ | 0-10 (10 WORST) _____ |

**HAVE YOU SEEN A DOCTOR IN THE PAST FOR THIS PROBLEM? YES/NO WHO, WHEN, WHERE?**

**EXPLAIN YOUR CONDITION OR HOW YOUR INJURY OCCURRED:**

**WHAT TREATMENT HAVE YOU HAD?** (PLEASE CIRCLE)
REST / MEDICATION / THERAPY / INJECTIONS / OTHER: _____

**HAVE YOU HAD ANY PREVIOUS DIAGNOSTIC TESTS?** (PLEASE CIRCLE)
MRI / X-RAY / CT SCAN / OTHER: _____

**CIRCLE ANY MEDICAL PROBLEMS LISTED THAT YOU HAVE OR HAVE HAD IN THE PAST:**

| | | |
|---|---|---|
| NO KNOWN MEDICAL PROBLEMS | HIGH BLOOD PRESSURE | HEART DISEASE/HEART ATTACK |
| LIVER DISEASE/HEPATITIS | DIABETES | COPD/EMPYSEMA |
| ULCERS | CANCER | TUBERCULOSIS |
| THYROID DISEASE | IMMUNE DISORDER | BONE INFECTION |
| PERIPHERAL VASCULAR DISEASE | ASTHMA | SEIZURE DISORDER |
| STROKE | SLEEP APNEA | OVERWEIGHT / OBESITY |

OTHER: _____

**TOBACCO USAGE? YES / NO**
PACKS PER DAY _____ HOW MANY YEARS_____

**ALCOHOL USAGE?**
NONE / OCCASIONAL / DAILY / >4 DRINKS/DAY

**HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING?**

| | | | |
|---|---|---|---|
| NONE KNOWN | CANCER | LEUKEMIA | CORONARY ARTERY DISEASE |
| RHEUMATIC FEVER | DIABETES | HYPOTHYROIDISM | HIGH BLOOD PRESSURE |
| TUBERCULOSIS | COLITIS | STROKE | BLEEDING TENDENCY |
| ASTHMA | SEIZURES | OTHER: _____ | |

**WHAT SURGERIES HAVE YOU HAD IN THE PAST?**

| | | | |
|---|---|---|---|
| NO PREVIOUS SURGERY | HYSTERECTOMY | MASTECTOMY | APPENDECTOMY |
| HERNIA REPAIR | CABG/OPEN HEART | GALL BLADDER | CATARACT EXTRACTION |
| PROSTATE SURGERY | LUMBAR SPINE SURGERY | TONSILLECTOMY | OTHER: _____ |

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## MEDICATION / ALLERGY SHEET

NAME: _____ D.O.B. _____

**WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?**
PLEASE INCLUDE BOTH PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS:

| MEDICATION | DOSE | # TIMES A DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**CIRCLE ANYTHING LISTED BELOW TO WHICH YOU ARE ALLERGIC:**

NO KNOWN DRUG ALLERGIES
PENICILLIN
TETRACYCLINE
SULFA
MORPHINE
CODEINE
IODINE / BETADINE
RADIOGRAPHIC DYES
ADHESIVE TAPE
ERYTHROMYCIN
OTHER (SPECIFY):

_____
_____
_____
_____
_____

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# REVIEW OF SYSTEMS

NAME: _____ D.O.B. _____

PLEASE CIRCLE ALL THAT CURRENTLY APPLY

**GENERAL, CONSTITUTIONAL:**

GOOD GENERAL HEALTH
RECENT WEIGHT CHANGE
FATIGUE
FEVER

**EYES AND VISION:**

WEAR GLASSES/CONTACTS
BLURRED/DOUBLE VISION
EYE DISEASE OR INJURY
GLAUCOMA/CATARACT

**EARS, NOSE, THROAT:**

SWOLLEN GLANDS IN NECK
EARACHES OR DRAINAGE
SINUS PROBLEMS
RINGING IN EARS
HEARING LOSS
NOSE BLEEDS

**RESPIRATORY:**

SHORTNESS OF BREATH
ASTHMA OR WHEEZING
FREQUENT COUGHING
SPITTING UP BLOOD

**CARDIOVASCULAR:**

SWELLING OF EXTREMITIES
IRREGULAR HEARTBEAT
HEART TROUBLE
CHEST PAINS

**GASTROINTESTINAL:**

CHANGE IN BOWEL MOVEMENTS
NAUSEA/VOMITING/DIARRHEA
LOSS OF APPETITE
CONSTIPATION
BLOOD IN STOOL
ULCERS

**GENITOURINARY:**

BURNING/PAINFUL URINATION
STRAIN WITH URINATION
FREQUENT URINATION
BLOOD IN URINE
KIDNEY STONES
INCONTINENCE
FREQUENT UTI

**MUSCULOSKELETAL:**

JOINT PAIN/STIFFNESS/SWELLING
WEAKNESS OF MUSCLES/JOINTS
CHANGE IN HAT OR GLOVE SIZE
MUSCLE PAIN OR CRAMPS
DIFICULTY WALKING
COLD EXTREMITIES
BACK PAIN

**NEUROLOGICAL:**

LOSS OF CONSCIOUSNESS
LIGHT HEADED OR DIZZY
NUMBNESS OR TINGLING
SEIZURE OR STROKE
SEVERE HEADACHES
HEAD INJURY
PARALYSIS
TREMORS

**PSYCHIATRIC:**

MEMORY LOSS/CONFUSION
SLEEP PROBLEMS
NERVOUSNESS
DEPRESSION

**ENDOCRINE:**

EXCESSIVE THIRST/URINATION
GLAND/HORMONE PROBLEM
HEAT/COLD INTOLERANCE
CHANGE IN SKIN COLOR
THYROID DISEASE
RASH OR ITCHING
DIABETES
DRY SKIN

**LYMPHATIC/ HEMATOLOGICAL:**

EASILY BRUISE OR BLEED
SLOW TO HEAL AFTER CUT
TRANSFUSION REACTIONS
PHLEBITIS/BLOOD CLOTS
SWOLLEN GLANDS
ANEMIA

# OKLAHOMA CENTER FOR ORTHOPAEDIC & SPORTS MEDICINE

**PLEASE PRINT**

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

## PATIENT INFORMATION

| Date | Referring Physician | Referring Physician Phone |
|---|---|---|
| | | |

| Last | First | Middle | Sex |
|---|---|---|---|
| | | | ❑ M ❑ F |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

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

| 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 | | | | Insured's Sex | | Insured's SS# |
|---|---|---|---|---|---|---|---|
| / / | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | ❑ M | ❑ F | — — |

| 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 | | | | Insured's Sex | | Insured's SS# |
|---|---|---|---|---|---|---|---|
| / / | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | ❑ M | ❑ F | — — |

| 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 B.M.S.I. (405) 685-0177 • OKC266- Form # R-0003 (Rev. 07/12)


**M. Sean O'Brien, D.O.** **Rory C. Dunham, D.O.**

## 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)


**M. Sean O'Brien, D.O.** **Rory C. Dunham, D.O.**

# WORKER'S COMPENSATION

Patient: _____ DOB_____ SS#_____

Patient Address:_____
Street City State Zip

Home Phone: _____ Mobile/Cell_____

Employer: _____ Employer Phone: _____

Employer Address:_____
Street City State Zip

Are you claiming this as an on the job injury? ___Yes ___No **Date of Injury:** _____

What type of injury? _____ How did it occur? _____

Has your employer been informed of the injury? ___Yes ___No Supervisor:_____

Work Comp Company_____

Work Comp Address_____
Street City State Zip

Contact Person: _____ Phone #: _____ Fax #:_____

Nurse Case Manager:_____ Phone #:_____ Fax #:_____

**Claim Number** _____ Verified By _____

If yes, are you receiving compensation? ___Yes ___No

Do you have an attorney? ___Yes ___No if yes, who _____

Were you referred to our office? ___Yes ___No if yes, who _____

Have you been treated by any other Doctor for this injury? ___Yes ___No

If yes, who_____ Phone Number _____

Doctor Name: _____ Appointment:_____ Scheduled by:_____

mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy, or other health care provider to whom we may refer you for consultation, to take x-rays, to preform lab tests, to have prescriptions filled, or for other treatment purposes. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information abut you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**For Payment:** We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

**For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

**Appointment Reminders:** We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

**As Required By Law:** We will disclose health information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.



**Workers' Compensation:** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks:** We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person or organization required to receive information on FDA-regulated products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement:** We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
  - Name and address
  - Date of birth or place of birth;
  - Social security number;
  - Blood type or rh factor;
  - Type of injury;
  - Date and time of treatment and/or death, if applicable; and
  - A description of distinguishing physical characteristics.
- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;



- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

**Coroners, Health Examiners and Funeral Directors:** We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities:** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Protective Services for the President and Others:** We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Privacy Officer, and must be contained on one page of paper legibly handwritten or typed in at least 10 point font size. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does

not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

**Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14th, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not be exceed a total of 60 days from the date you made the request.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

***We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Privacy Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to Privacy Officer. We will not ask you the reason for your request. We



will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from Privacy Officer.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services by mail: Office of Civil Rights Region VI, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. To file a complaint with us, contact Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

**OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**Acknowledgment of Receipt of this Notice**

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgment will be filed with your records.

OKLAHOMA CENTER
FOR ORTHOPAEDICS
& SPORTS MEDICINE

Effective Date: April 14th, 2003



OKLAHOMA CENTER
FOR ORTHOPAEDICS
& SPORTS MEDICINE

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

Effective Date: April 14th, 2003

# HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

**PLEASE REVIEW THIS DOCUMENT CAREFULLY**

If you have any questions about this notice, please contact Privacy Officer by telephone at (405) 759-2663.

**WHO WILL FOLLOW THIS NOTICE:**

- Oklahoma Center for Orthopaedic & Sports Medicine, 3110 S.W. 89th, Suite 200C, Oklahoma City, OK 73159

This notice describes our privacy practices. We are affiliated with:

- Oklahoma Center for Orthopaedic & Sports Medicine, 3110 S.W. 89th, Suite 200C, Oklahoma City, OK 73159

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

**OUR PLEDGE REGARDING HEALTH INFORMATION**

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we

# PHARMACY INFORMATION

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

**Attn Tricare pts: Please note that we are not able to call-in, fax, or E-prescribe prescriptions to military post/base pharmacies. You we need to provide us with a civilian pharmacy that accepts your insurance.**

**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. Dr. Sean O'Brien 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 |

Dated: _____

Community Hospital

Community Hospital OUTPATIENT THERAPY

Community Hospital

Northwest Surgical Hospital

LakePointe IMAGING CENTER