Gerardo Myrin, M.D.
Oklahoma Sports Science and Orthopaedics
3115 S.W. 89TH Oklahoma City, OK 73159 – P: 405.486.6880 - F: 405.486.6899

IMPORTANT INFORMATION PLEASE READ CAREFULLY**

You have been scheduled for an evaluation with Dr. Gerardo Myrin, M.D., Orthopedic Hip and Knee Reconstructive Specialist.
In order to provide you with the best possible patient experience and to be able to provide you with the specialty opinion you are seeking, it is very important that you read this carefully and bring all of the following items with you for your appointment.

What to Bring:

- **Identification (driver's license or state issued ID card)**
- **Insurance Card(s)**
- **Co-pay**
- **Completed New Patient Paperwork and Health History**
- **Any Diagnostic testing (CD's/discs/formal reports) that pertain to the body part we are seeing you for**
- **Medical records that pertain to the body part we are seeing you for**
- **List of all medications you are currently taking (with exact names and dosages)**
- **Names and addresses of any providers currently involved in your care/prescribing medications for you**
- **List of all past surgeries and details of any complications that you have had pre/post operatively**

Dr. Myrin will most likely be obtaining additional or new X-rays during your visit as well as performing an in-depth examination. Please dress comfortably (loose fitting clothing/shorts/athletic pants) if possible to allow for easy completion of all components of your visit.

Dr. Myrin's goal is to run on time in clinic and to be a proper steward of your time while you are a guest in our office. This preparation on your part will assist him in not only respecting your time, but the time of everyone who has selected him to participate in their care.

Failure to prepare for this appointment could result in the postponement of your appointment so as to enhance your time in our office and to ensure your needs are met*

Dr. Myrin's team is always available and welcomes your call for assistance or clarification on any of these items or to answer any questions you may have prior to your visit with us.

APPOINTMENT DATE:_____ **TIME:** _____

Our office is located on SW 89th Street between I-44 and May Avenue. We are directly across the street from Community Hospital and Fountain Park Medical Plaza. We are located on the North side of the road.

We look forward to seeing you and thank you for choosing us to be a part of your healthcare team!

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OSSO
AN HPI AFFILIATE

PATIENT INFORMATION

Date	Referring Physician		Referring Physician Phone	
Last	First		Middle	Sex: ____M ____F
Address	City		State	Zip
Home Phone	Age	DOB:	Marital Status: S M W D DEP	SS#
Employer/School	Address	City	State	Zip
Work Phone	Cell Phone	Pager	E-Mail	
Nearest Relative (other than spouse)		Relation	Contact Number	

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient		Home Phone	
Address	City		State	Zip
Employer	SS#	DOB	Age	Work Phone:

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance		Insurance Type Group _____ Individual _____ COBRA _____	
Address	City	State	Zip
Insured's Name on Card		ID#	Group#
Insured's DOB	Relation to Insured	Insured Sex M ___ F ___	Insured SS#
Insured's Employer		Insured's Phone	

Secondary Insurance		Insurance Type Group _____ Individual _____ COBRA _____	
Address	City	State	Zip
Insured's Name on Card		ID#	Group#
Insured's DOB	Relation to Insured	Insured Sex M ___ F___	Insured SS#
Insured's Employer		Insured's Phone	

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 Sports Science and Orthopaedics. I am financially responsible for any charge not covered by my insurance.

_____ _____

Patient or Authorized Person Date

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PHARMACY INFORMATION

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

Tricare Patients: Please note that we are unable to call-in, fax or e-prescribe prescriptions to military post/base pharmacies. Please provide us with a civilian pharmacy that accepts your insurance.

PHARMACY: _____

ADDRESS: _____

PHONE: _____

All questions must be filled in. Please do not leave anything blank.

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

Patient's Signature: _____

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DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

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

1. Dr. Gerardo M. Myrin 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 healthcare 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 visits our website(s), 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/Guardian (if applicable)

_____ _____
(Print Name of Patient) Print Name of Parent or Guardian

_____
Date

HPI COMMUNITY HOSPITAL

HPI NORTHWEST SURGICAL HOSPITAL

HPI COMMUNITY HOSPITAL IMAGING CENTER

HPI COMMUNITY HOSPITAL OUTPATIENT THERAPY

HPI NORTHWEST SURGICAL HOSPITAL LAKEPOINTE IMAGING CENTER

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____, acknowledge that I have received a copy of The Physicians' Group or HPI Physicians, LLC ("the Practice")Notice of Privacy Practices ("the Notice"). This Notice describes how the practice 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

_____
(Relationship 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
Name	Relation to patient
Name	Relation to patient

_____
(Patient Signature) Date

_____
(Parent or Guardian) Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how The Physicians' Group, LLC or HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment and healthcare operations.
- The Notice explains in more detail how the Practice may use and share protected health information other than treatment, payment and healthcare operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient Name (print): _____

Patient Date of Birth: _____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

_____

_____

_____ Date:_____
(Signature of Patient or Patient's Personal Representative)

Current contact information for patient or personal representative signing this form:

Name (print): _____

Address: _____

Telephone: _____

E-mail: _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgement but did not because:

_____ It was emergency treatment
_____ I could not communicate with the patient
_____ The patient refused to sign
_____ The patient was unable to sign because _____
_____ Other: _____

_____ _____ _____
Signature Practice Staff Member | Name (please print) and title | Date

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Print Patient Name: _____ DOB: _____

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

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

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine not prescribed to me.
2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. I will not increase my medicine until I speak with my doctor or nurse.
4. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
5. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
6. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
7. I agree to come to the office for a pill count at any time if asked by my doctor.
8. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
9. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test, and I will be responsible for the payment.
10. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
11. I have been informed by my physician about narcotic effects, including the normal physiological effects of tolerance (where I might need to take more medication to obtain the same pain relief), and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
12. I understand that narcotics can adversely affect my judgment in making business decisions, and in operating equipment such as an automobile.
13. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy substances like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.

Refills

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

Termination of Agreement

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

I understand the above rules and that Dr. Hogan is NOT a pain management doctor and will not take over care of prescribing narcotics.

Patient's signature: _____Date:_____

Signature of Parent or Authorized Personel:_____Date:_____

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OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

A DIVISION OF THE PHYSICIANS' GROUP

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopaedics (OSSO) are you healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care. We specialize in adult and pediatric orthopaedics, sports medicine, physical medicine and rehabilitation, pain management, reconstructive and orthopedic 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 providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card, or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 405.692.3708 to make financial 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 (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. **Please note that not all OSSO Physicians will accept third party/MVA patients.**

There is a $35 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 other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, 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 & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed_____ Date_____
(Signature of person financially responsible for payment)

Relationship if other than patient_____

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AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopaedics 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 & Orthopaedics 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 & Orthopaedics charge or who may be responsible for determining the necessity, appropriateness, amount or maintenance organizations, preferred provider 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 DEFIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, its agents and its employees from liability in connection with the release of the information contained within.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Sports Science & Orthopaedics. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliated to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Sports Science & Orthopaedics from any claim for responsibility or damages in the event of loss of my property, Including money and jewelry.

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

SIGNED:_____ DATE: _____
(Patient Signature)

OR: _____ DATE: _____
(Signature of Parent or Personal Representative)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

Name_____**Age:** _____**DOB**_____**Date**_____

Please tell us why you are here today: (For previously replaced joints, also complete next page)

Hip Pain: ☐Right ☐Left ☐ Both hips **If the pain is located in your hip, do you have pain in any of the following?** ☐in your groin area ☐side of your hip ☐buttocks ☐back ☐radiation to your leg L/R	**Knee Pain:** ☐Right ☐ Left ☐ both knees ☐ inside of knee ☐outside of knee ☐ front of knee ☐ back of knee ☐ under the knee cap ☐ all over knee

When did this begin? ____years ____months ____weeks ago. ☐Gradual or ☐Sudden?

Please describe your pain:
☐aching ☐throbbing ☐dull ☐sharp ☐burning ☐shooting ☐stinging
What is your **pain level** with **rest** based on a scale of 1-10? _____
What is your **pain level** when you are **active** on a scale of 1-10?_____

Please check the **symptoms** you experience:

- ❑ pain
- ❑ swelling
- ❑ stiffness
- ❑ instability
- ❑ difficulty standing
- ❑ difficulty walking
- ❑ difficulty with stairs
- ❑ difficulty dressing (shoes/socks)
- ❑ difficulty toileting
- ❑ difficulty changing positions
- ❑ warmth
- ❑ redness
- ❑ bruising (ecchymosis)
- ❑ locking
- ❑ audible pop with injury

What have you tried to deal with this pain?

- ❑ attempted weight loss (____lbs)
- ❑ advil/aleve for 4 wks
- ❑ unable to take advil/aleve
- ❑ physical therapy @ least 12 wks
- ❑ unable to complete PT due to pain
- ❑ brace/cane/walker/wheelchair (**circle**) for 12 wks
- ❑ no relief with Brace/Cane/ Walker/WC
- ❑ steroid injection
- ❑ gel/visco injection
- ❑ avoid activity that causes pain
- ❑ home flexibility/strength exercises
- ❑ mobic/celebrex
- ❑ tylenol
- ❑ topical/cream
- ❑ tramadol
- ❑ norco/hydrocodone
- ❑ percocet/Vicodin/oxycodone
- ❑ Other: _____

Medical History
Do you have allergic reaction to: ☐iodine ☐ latex ☐metal/jewelry ☐medications, list on last page
Check all that apply:

(Blood Clot Risk)	(TXA Risk)	(Infection RIsk)
❑ • AFIB/Blood thinner	❑ Seizure	❑ • Hx of MRSA
❑ • Blood Clot DVT/PE	❑ Blood clot DVT/PE	❑ • Immunosuppressant
❑ • COPD	❑ Clotting disease	❑ • Rheumatoid med
❑ • Anemia	❑ • Ischemic stroke	❑ • Transplant
❑ • Depression	❑ • CAD	❑ • Long term steroid use
❑ • BMI>25	❑ • Stents (heart/leg)	
❑ • Older than 50	❑ • Kidney failure	Wound risk
❑ • Diabetes		❑ BMI >35
❑ • Liver disease		❑ BMI <18
❑ • Cancer		❑ Diabetes
❑ • Heart failure CHF		❑ smoking/COPD
❑ • stroke		❑ malnutrition

If we are seeing you for a **previous joint replacement**, please bring medical records and xrays of the surgery:

When, where, who performed your previous surgery(ies):
Year_____ Location/Surgeon:_____ Surgery:_____
Year_____ Location/Surgeon:_____ Surgery:_____
Year_____ Location/Surgeon:_____ Surgery:_____

After your joint replacement, **did your pain**: ☐ Stay the same ☐ Improve ☐ Become worse

Did you have any of the following **complications**: ☐continued pain ☐instability ☐stiffness ☐ slow healing of the incision ☐ drainage ☐ infection ☐ blood clot ☐ fracture ☐ dislocation ☐repeat operation ☐ allergy to implant

For office use only: ***Laterality:*** ☐ Left ☐ Right ☐ Bilateral ☐ Knee ☐ Hip
Dx: ☐ OA ☐ AVN ☐ failed/pain ☐ unstable ☐ Post-Traumatic ☐Septic ☐ Rheumatoid ☐PJI ☐PFx ☐ Metal Allergy

Non-op:
☐ Weight loss ☐ Home Ex ☐ Celebrex/ Mobic ☐tylenol ☐tramadol ☐ Steroid / Visco ☐ PT ☐ Cane/ Walker ☐Brace

Work-up: ☐PAT ☐CBC ☐ CMP ☐ESR ☐CRP ☐ IL-6 ☐ MoM ☐Rheum ☐ Bone ☐Anemia ☐ Nutrition
☐Aspiration with:
- synovial fluid analysis
- aerobic Cx (hold for P acnes)
- anaerobic Cx (hold for mycoplasma)
- AFB Cx
- Fungal Cx
- Synovasure
- Microgen

☐ iliopsoas injection
☐ Metal allergy testing ☐ M8 tests ☐P12 tests
☐ Cobalt ☐ Chromium
☐ DVT Duplex ultrasound BLE
☐ X-ray ☐ pelvis ☐ hip ☐ knee ☐ bone length scan/full length
☐ CT scan ☐with MARS protocol
☐ MRI ☐with MARS protocol
☐ SPECT/CT
☐ Bone Scan

Procedure:
☐ Partial Knee vs Total Knee Replacement
☐ Patellofemoral vs Total Knee Replacement
☐ Total Knee Replacement
☐ Revision Knee Replacement
☐ Core Decompression
☐ Partial Hip Replacement
☐ Total Hip Replacement
☐ Revision Hip Replacement
☐ Other: _____
Referal: ☐Spine ☐Rheumatology ☐ PCP ☐ Ortho:_____ ☐ Other: _____
Follow up: ☐ 2 weeks ☐6 weeks ☐ 3 months ☐ at 1 year post-op ☐ 2 year post-op ☐5 year post-op

EXAM: B/P_____ P_____ Ht:_____ Wt: _____ BMI_____ Antalgic Aid_____
HIP: **R:** normal DJD
L: normal DJD
TEST: **R:** LLD Log roll Resisted SLR SLR FADIR FABER Contracture
L: LLD Log roll Resisted SLR SLR FADIR FABER Contracture
KNEE: **R:** normal DJD stable unstable
L: normal DJD stable unstable

CURRENT MEDICATIONS: (Please include over the counter medication and food supplement.) Please note the specific name of the medication, the dosage that you take daily i.e. 10mg and how often you take the medication.

- ❑ Check this box if you currently **DO NOT TAKE** any medications

1. Medication Name_____ Dose_____How Often:_____
2. Medication Name_____ Dose_____How Often:_____
3. Medication Name_____ Dose_____How Often:_____
4. Medication Name_____ Dose_____How Often:_____
5. Medication Name_____ Dose_____How Often:_____
6. Medication Name_____ Dose_____How Often:_____
7. Medication Name_____ Dose_____How Often:_____
8. Medication Name_____ Dose_____How Often:_____
9. Medication Name_____ Dose_____How Often:_____
10. Medication Name_____ Dose_____How Often:_____

Please list all **ALLERGIES** to include the reaction you have.

- ❑ **Check this box if you currently DO NOT have any allergies**

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

Allergy_____ Reaction_____

What is your preferred Pharmacy?

Pharmacy Name_____ Phone#_____

Address_____

What is your preferred MAIL ORDER Pharmacy?

Pharmacy Name_____ Phone#_____

Please list any other physicians you see, to include their first and last name:

Primary Care Physician_____

Rheumatologist_____

Cardiologist_____

Other (please list specialty)_____

Other (please list specialty_____