ORTHOPAEDIC & SPORTS MEDICINE CENTER

Name:_____ **Date of Birth:**_____ **Date:**_____

Primary Care Physician:_____ **Referred By:**_____

History of Present Illness:

Reason for Visit: ☐ Right ☐ Left _____

Is this related to a: ☐ Work Injury ☐ Motor vehicle accident ☐ Sports Accident ☐ Other _____

When did this begin?:_____ **If chronic, how long?**_____

Please describe in your own words how the injury occurred and how it limits your activity?_____

Please rate your pain: **At Rest:** 0 1 2 3 4 5 6 7 8 9 10 **At Worst:** 0 1 2 3 4 5 6 7 8 9 10

Describe the pain (mark all that apply): ☐ Constant ☐ Occasional

Is it: ☐ Worsening ☐ Stable ☐ Improving

Character: ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Other:

Symptoms: ☐ Locking ☐ Catching ☐ Giving way/Instability ☐ Popping ☐ Grinding
☐ Bruising ☐ Numbness ☐ Tingling ☐ Pain ☐ Weakness ☐ Swelling

What, if anything, makes your symptoms better?

☐ Rest ☐ Activity ☐ Cold / Heat Therapy ☐ Tylenol/Ibuprofen ☐ PT ☐ Other:_____

What, if anything makes your symptoms worse?

☐ Inactivity ☐ Exercise (describe): ☐ Other:_____

What treatments have you tried for this injury?

☐ Nothing ☐ Exercise ☐ Ice ☐ Decreased Activity ☐ Bracing ☐ Injections (type):
☐ Physical Therapy (date started): ☐ Medications: ☐ Other (describe):_____

Medical History:

Please select any problems you **currently have** or **have had** in the past: ☐ **NONE APPLY TO ME**

☐ Aids / HIV	☐ Congestive Heart Failure	☐ Heart disease / attack	☐ Osteoporosis
☐ Alcoholism	☐ COPD	☐ Heartburn	☐ Pulmonary Emboli
☐ Anemia	☐ Depression	☐ Hepatitis (type):_____	☐ Rheumatoid arthritis
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Seizure disorders
☐ Asthma	Taking Insulin? ☐ Y ☐ N	☐ High cholesterol	☐ Stomach ulcer / GERD
☐ Atrial Fibrillation	☐ Drug abuse	☐ Kidney Disease	☐ Stroke
☐ Blood clots / DVT	☐ Fibromyalgia	☐ Liver Disease	☐ Thyroid problems
☐ Cancer (type):_____	☐ Fracture (location):	☐ Lupus	☐ Other:_____
_____	☐ Gout	☐ MRSA	_____

Surgical History:

Please list all previous surgeries and the approximate year: ☐ **NO SURGICAL HISTORY**

Surgery:	Date:	Surgery:	Date:

Any difficulties or complications from anesthesia? ☐ Yes ☐ No **Type:**_____

Family History:

Please check the box if anyone in your immediate family (parents, brothers, sisters, children) have any of the following.

- ☐ Ankylosing spondylitis:
- ☐ Asthma
- ☐ Blood clots
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Anesthesia problems
- ☐ Other:_____

_____

Social History:

Occupation:_____ **Are you currently working**? ☐ Yes ☐ No ☐ Retired ☐ Limited Duty

Recreational/Sporting Activity:_____

Do you exercise: ☐ Yes ☐ No **Frequency**: _____ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Former ☐ Smoke ☐ Chew **Amount**: ____ packs (cans)/day _____ years

Alcohol Use (drinks per day): ☐ None ☐ Occasional ☐ 2-3 ☐ >4

Caffeine: ☐ Yes ☐ No **Frequency**:_____ **Recreational Drugs**: ☐ Yes ☐ No **Type**: _____ **Frequency**:_____

Review of Systems:

Are you **CURRENTLY** experiencing any of these problems **TODAY**? ☐ **NONE APPLY TO ME**

Constitutional			**Gastrointestinal**			**Neurologic**		
Fatigue	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	Difficulty Walking	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Head/Eyes/Ears			Nausea/Vomiting	☐ Yes	☐ No	**Integumentary**		
Headache	☐ Yes	☐ No	**Genitourinary**			Skin Rash	☐ Yes	☐ No
Visual loss	☐ Yes	☐ No	Painful urination	☐ Yes	☐ No	**Hematologic**		
Respiratory			Blood in urine	☐ Yes	☐ No	Easy Bleeding	☐ Yes	☐ No
Cough	☐ Yes	☐ No	**Endocrine**			Easy clotting	☐ Yes	☐ No
Short of Breath	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No	**Immunologic**		
Cardiovascular			Heat / Cold Intolerance	☐ Yes	☐ No	Environmental allergy	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No				Food allergy	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No						

Allergies

Are you allergic to: ☐ Sulfa drugs ☐ Penicillin (PCN) ☐ Latex ☐ Steroids ☐ **NO KNOWN DRUG ALLERGIES**

Other Medication Allergies (and reaction):_____

_____

Medications: (please list all prescription, over the counter, and supplements)

Medication	Dosage	Frequency

Patient Signature:_____ Date:_____

Office Use Only

Review date: _____ Provider Initials: _____

_____ _____

ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Referring Physician: _____ Primary Physician: _____

Patient Name: _____
Home Address: _____ P.O. Box: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Sex: M / F SS#: _____
Language: _____ Ethnicity/Race: _____ Marital Status: S M W D
Home Phone: _____ Cell Phone: _____
E-Mail Address: _____
Employer: _____ Work Phone: _____
Emergency Contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

-Reason for Appointment-

What are we seeing you for today? _____

_____

Body Part? LEFT / RIGHT / Bilateral _____
Due to Injury? YES / NO Injury Date: _____ If no injury, Date of Onset: _____
Where did injury occur? _____
How did injury occur? _____

For Insurance purposes we are required by Federal Regulations to obtain the above information.

Worker's Compensation Related? YES / NO **Auto Related?** YES / NO **Other Liability Related?** YES / NO

-Person Responsible for Payment of Account-

Name: _____ Relationship: _____
Address: _____ Home Phone: ( ) _____
City, State, Zip: _____ Other Phone: ( ) _____

-Insurance Information-

Please Present Card(s) for Copying

Primary Insurance: _____ Policy#: _____ Group#: _____
Policy Holder's Name: _____ DOB: _____
Secondary Insurance: _____ Policy#: _____ Group#: _____
Policy Holder's Name: _____ DOB: _____

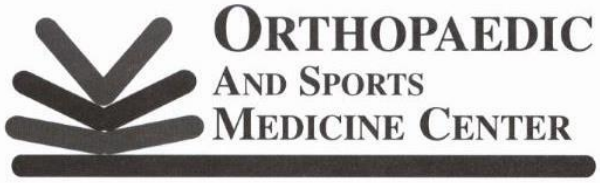
Orthopaedic and Sports Medicine Center, LLP (OSMC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OSMC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

THIS IS NOT AN AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Orthopaedic and Sports Medicine Center to furnish information to insurance carriers/Medicare/Medicaid concerning my illness and treatment. I assign to the physicians all payments for medical services rendered to myself or my dependents, regardless of custody arrangements.

Accounts are due and payable monthly as treatment progresses, regardless of legal insurance coverage.

Signature of Patient, Parent, or Legal Guardian of Patient: _____ Date: _____



1600 Charles Place, Manhattan, KS 66502

Permission to Share Your Orthopaedic and Sports Medicine Center Medical Information

_____
Patient's Name

Other than myself, my medical information (including, but not limited to, office exam notes, lab results, billing info, etc.) may be shared with:

Relationship	Name of Person
_____ Spouse	_____
_____ Mother	_____
_____ Father	_____

_____ Other Family Member or Friend (Please list name and relationship)

_____

_____

_____

_____ None

_____ _____
Signature of Patient or Patient Representative Date

If Patient Representative, what is your relationship to patient? _____

For a patient's medical records to be released from this facility, the patient must contact the Orthopaedic and Sports Medicine Center's Medical Records Department for a separate Authorization to Release Medical Information.

1600 Charles Place, Manhattan, KS 66502

MEDICARE SECONDARY PAYER QUESTIONNAIRE
(TO BE COMPLETED BY ALL MEDICARE PATIENTS)

NAME: _____ Date _____

BODY PART: _____(CIRCLE ONE) LEFT RIGHT BILATERAL

	YES	NO
1. Is the patient a Veteran?	_____	_____
a. Did the VA refer the patient here for treatment?	_____	_____
b. Does the patient have a VA "fee basis ID Card"?	_____	_____
2. Does the patient have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If YES, was it: Work Related ☐ Auto ☐ Injured in own home ☐ Other ☐

If injury occurred anywhere other than own home:	_____	_____
• Has another party been found responsible?	_____	_____
• Are you filing a claim with the no-fault insurance or the liability insurance?	_____	_____
• Are you receiving work comp benefits?	_____	_____

If YES to any of the above questions, please provide the billing information in the space below.

4. In addition to Medicare, is the patient covered by a Health Insurance plan through his/her own employment or employment of a spouse (not retiree coverage)?	_____	_____
If YES, do 20 or more employees work for the employer?	_____	_____

If YES, please provide billing information in the space below.

OTHER INSURANCE information:

_____
Name of Insurance

_____
Address

_____

_____
Policy holder name and date of birth

Orthopaedic & Sports Medicine Center
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact
Orthopaedic & Sports Medicine Center Privacy Officer
785-537-4200
(Fax) 785-537-4354

Orthopaedic & Sports Medicine Center is permitted by federal privacy laws to make uses and disclosures of your health information without your authorization for purposes of treatment, payment, and health care operations. The other ways that Orthopaedic & Sports Medicine Center is permitted to use and disclose your protected health information are described below.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal documents describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your records and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request restrictions on specific uses and disclosure of your information. We do not have to agree to this request unless you self-pay for a service and request that your insurer not be billed.
- Obtain an electronic or paper copy of the notice of health information privacy practices upon request
- Inspect and obtain an electronic or paper copy of your health record. You may be charged a cost-based fee for copies
- Request an Amendment be made to your health record
- Obtain an accounting of disclosures of your health information

- Request confidential communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Be notified in the event that there is a breach of your health information

Our Responsibilities

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction, communication accommodation, request for amendment, request for accounting, or request for access
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you if your health information has been subject of a breach

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice within the clinic at the reception area. You are entitled to a revised copy upon request.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the Privacy Officer at 785-537-4200. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer at 785-537-4200 or with the Region VII Office of Civil Rights in Kansas City. Regional Manager Office for Civil Rights; U.S. Department of Health and Human Services: 601 East 12th Street – Room 248 Kansas City, Missouri 64106; Voice Phone 816-426-7278; FAX 816-426-3686 TDD 816-426-7065 or: Office for Civil Rights; U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 515F HHH Bldg. Washington, D.C. 20201. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

Examples of Uses and Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the action they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.

For Example: A bill may be sent to you or a third-party payer (i.e. insurance company). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We can continue to make these communications after your death.

We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

We will request that you authorize disclosures of psychotherapy notes, for marketing purposes, or if we receive any remuneration for your health information.

Uses and Disclosures that may be made without your authorization

Appointment Reminders and Treatment Follow up: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment of medical care at the Orthopaedic & Sports Medicine Center or regarding follow up of a previous appointment. Unless you direct us to do otherwise, we may leave messages on your telephone answering machine identifying Orthopaedic & Sports Medicine Center and asking for you to return our call. Unless we are specifically instructed by you otherwise in a particular circumstance, we will not disclose any health information to any person other than you who answers your phone except to leave a message for you to return the call.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in radiology and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information revelant to that person's involvement in our care or payment related to you case. Unless you tell us otherwise, this communication may continue after your death.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing and Fundraising: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use your health information for fundraising but will provide you with a way to inform us if you do not want to receive fundraising materials. We will not sell your health information without your authorization.

Surveys: We may contact you to complete a patient satisfaction survey following a visit to our office.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. With your consent we can disclose immunization information to schools. We also report child abuse or neglect and adult abuse or neglect.

Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Required by Law: We may use and disclose your health information when the law requires us to do so.

Serious Threat to Health or Safety: We may use or disclose your protected health information when necessary to prevent a serious threat to your health or the health and safety of another person.

Organ and Tissue Donation: We may use or disclose your protected health information to an organ donation bank or other organizations that handle organ procurement to assist with organ or tissue donation and transplantation.

Military and Veterans: The protected health information of member of the United States Armed Forces or members of a foreign military authority may be disclosed as required by military command authorities.

Employers: We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. We will tell you when we make this type of disclosure.

Legal Proceedings: We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.

Coroners, Medical Examiners, and Funeral Directors: We may disclose your protected health information to a coroner, medical examiner, or a funeral director.

National Security and Intelligence Activities: When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.

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

Inmates or Persons in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or a law enforcement official when it is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.

Effective date: April 14, 2003
Revised: July 1, 2013

ORTHOPAEDIC
AND SPORTS
MEDICINE CENTER

Financial Policy

Welcome to the Orthopaedic and Sports Medicine Center. We are pleased you have chosen our orthopaedic surgeons for your orthopaedic needs. Our dedicated billing staff is here to assist you with your account and help with any insurance issues you may encounter. We make every effort to keep down the cost of your medical care. Our office and surgical fees are determined by the complexity of the procedure, time involved and the fee that is usual and customary for our area. Services such as diagnostic x-rays and/or treatments such as casts, splints, injections, physical therapy, etc., involve additional costs.

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions at all.

Please sign the attached "Financial Responsibility" form and return to us.

Self-Pay Patients

All Self-Pay patients and patients who present without proof of insurance are required to pay $200.00 deposit in cash, check, money order, or credit card at the time of service.

The actual visit charge may be higher. We will bill you for the difference.

Follow up appointments will run $100.00 to $150.00 and will be paid for at the time the service is rendered. All physical therapy appointments will be paid at the time services are rendered. The average physical therapy bill is $125.00 to $175.00 per appointment.

If you are facing fracture care or surgery, please plan to visit with one of our patient account specialists to work out acceptable arrangements for payment.

Failure to bring your expected payment may result in having to reschedule.

Patients with Health Insurance

Please bring your insurance information to every appointment and tell us when there are changes. We contract with many, but not all insurance carriers. We submit claims to all U.S. companies as a courtesy, however if we are not a contracted provider with your insurance company (i.e. out of network), we are not required to comply with their fee schedule.

If you have an auto related injury or are injured on someone else's property, we will need to file with that insurance before we can file with your health insurance.

If your insurance requires pre-authorization or a referral for any services, it is your responsibility to notify us in advance and/or obtain the referral.

Your insurance **requires** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. Without it, you may be required to reschedule.

Deductible and co-insurance must be paid within 30 days of insurance processing. Accounts not paid within 120 days of service will begin accruing interest charges at the rate of 1.5% per month.

Forms of Payment

We accept VISA, MasterCard, Discover, American Express, personal check, money order and cash. There is a $15.00 administration fee for returned checks. Payment by credit card is also available on our website, kansasortho.com.

Outstanding Balances

The Orthopaedic and Sports Medicine Center reserves the right to utilize a third party collection agency for account balances not settled in a timely manner. Failure to keep your account current may result in dismissal from the practice.

No Show Policy

Please notify us within 1 business day if you are unable to keep your appointment. "No Shows" will be charged $35.00.

Third Party Insurance Forms (Disability, FMLA, etc.)

There is a charge for completing any form that is not directly related to reimbursement of medical services. For compliance purposes, the patient information portion of the form must be completed and signed prior to acceptance, along with payment. Form fees must be paid in full prior to release.

Quick Pay Option

As a convenience to all of our patients, we offer "Quick Pay". We simply maintain your credit card in a secure file to capture any co-pays, deductibles, or charges not covered by your insurance. Receipts will be mailed to you when the credit card is used. Please visit with one of our patient accounts specialists if you would like to activate this option.

Any questions regarding this policy, please call our Patient Account Specialists at 564-4655 or our Financial Officer at 564-4640.

Orthopaedic and Sports Medicine Center

Notice of Privacy Practices

Addendum

2/22/2016

As explained in our Notice of Privacy Practices ("NPP"), health care providers and health plans may use and disclose your health information without your written authorization for purposes of treatment, payment, and health care operations. Until now, providers and health plans have exchanged this information directly by hand-delivery, mail, facsimile, and e-mail. This process is time consuming, expensive, not secure, and often unreliable.

Electronic health information exchange, or HIE, changes this process. New technology allows a provider or a health plan to submit a single request through a health information organization, or HIO, to obtain electronic records for a specific patient from other HIE participants.

An organization known as the Kansas Health Information Exchange, or KHIE, regulates HIOs operating in Kansas. Only properly authorized individuals may access information through an HIO operating in Kansas, and only for purposes of treatment, payment, or health care operations.

You have two options with respect to health information technology (HIT). First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to **all** of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

ORTHOPAEDIC
AND SPORTS
MEDICINE CENTER

Written Acknowledgement Form for

Notice of Privacy Practices (HIPAA)Financial Policy & Appointment Cancellation Smoking Cessation & BMI/Healthy Weight Management & Fall History

I, _____, acknowledge
(Patient Name Printed)

- I have been offered the opportunity to review and receive a copy of the Orthopaedic & Sports Medicine Center's **HIPAA policy and Financial policy**
  - The Complete Policies for HIPAA and Financial Responsibility are also available on our website @ www.kansasortho.com under Resources or at any of the receptionist's desks.
- Orthopaedic & Sports Medicine Center (OSMC) has my permission to provide medical documentation to my insurance company in order to obtain reimbursement.
- I understand that there may be a $35.00 charge if I do not call and cancel my appointment at least one (1) business day prior to the time scheduled.
- If I am a smoker, my OSMC physician does recommend that I contact my Primary Care Physician regarding a smoking cessation program. Smoking is harmful to my health and stopping smoking could improve my overall health status.
- BMI is a person's weight in kilograms divided by their height. If my BMI is not within normal parameters, my OSMC physician does recommend that I contact and consult with my Primary Care Physician for weight management guidance.
- Fall History: If I am 65 years old or older and I have had either two (2) falls in the last 12 months or one (1) fall resulting in injury, my OSMC physician does recommend that I contact Physical Therapy for a balance and gait assessment.

_____ _____

Patient (or Representative Guardian Parent (Signature) Date

ORTHOPAEDIC
AND SPORTS
MEDICINE CENTER

Controlled Substance Medication Agreement

Patient's Name: _____

I understand that Dr./PA-C/ARNP _____ (hereinafter referred to as "provider") is prescribing a controlled substance medication for pain management. This Controlled Substance Medication Agreement is a tool for communication, allowing me to work together with my provider in good faith and for me to understand the importance of this medication. In prescribing a controlled substance medication, my provider is trying to create the best treatment plan for my improvement and management of pain. This requires cooperation, trust and mutual respect. If I cannot agree with the following terms, no controlled pain medications will be prescribed. The failure to follow all terms of this Agreement will result in discontinuing the pain medication and/or dismissal from this orthopedic practice.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my provider.
2. I will keep regularly scheduled appointments with my provider. If my medication needs to be refilled between office visits I will call the office at least 1 to 2 days before my medication runs out. Refill requests will only be taken on Monday - Thursday from 8:30 am to 4:00 pm and Friday 8:30 am to 1:00 pm. Any request for controlled substance pain medications after 1:00 pm on Friday will not be considered for refill until Monday morning at 8:30 am. The on-call provider will not refill any pain medications after hours, on weekends, or holidays. If I have uncontrolled pain during a weekend, medical care should be sought from an emergency room or immediate care center.
3. The controlled substance pain medication prescribed is being given in order to control pain and improve function. If there are any changes to my activity level or physical condition, the treatment may be changed or discontinued. I am responsible for notifying my provider of such changes.
4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves. If my condition does not improve, my provider may recommend additional conservative or invasive orthopedic procedures. If my level of pain still does not allow me to taper and discontinue the controlled substance pain medication, I may be referred to a pain management specialist for management of my pain medications.
5. I agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.
6. I agree to NOT accept or seek controlled substance pain medication from any other physician or health care provider, including my primary care physician, while I am receiving prescribed pain medication from this orthopedic practice. It is essential that only one provider monitor and evaluate my use of pain medication.
7. If I have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), I will be asked to coordinate all medications with that prescribing provider.
8. It is required that I use a single pharmacy for all prescriptions. I may use a chain of pharmacies with different branches, as the prescription information is available at all branches. This is required to make certain that my medications are known by a pharmacist who is able to evaluate any concerns about interaction of medications.
9. I understand that lost, stolen or misplaced prescriptions or pills will not be replaced. I am required to act responsibly with my medications. This medication is prescribed for me and only my specific pain needs. To allow others to use my medication is illegal and dangerous. This type of behavior will not be tolerated by my provider and this orthopedic practice.
10. I agree that I will not use any other illegal and/or recreational drugs while receiving care and pain medication from this practice. Use of illegal and/or recreational drugs, especially while also taking pain medication, is extremely dangerous and potentially lethal.

Patient Signature: _____ **Date:** _____