OXFORD ORTHOPAEDICS
& SPORTS MEDICINE, PLLC

497 Azalea Drive, Suite 102
Oxford, MS 38655
P: 662.513.2000 Fax: 662.513.2001
oxfordortho.org

PATIENT PROFILE

Name _____
Preferred _____
Mailing Address _____
_____
City,State _____
Physical Address _____
_____
Alt City, State _____
Phone _____ [ ]Home [ ]Work [ ]Other
Phone _____ [ ]Home [ ]Work [ ]Other

Date of Birth _____ Sex: [ ]Male [ ]Female
Social Security # _____
Marital Status [ ]Married [ ]Single [ ]Divorced [ ]Widowed
Referring Physician _____
Primary Physician _____
Email Address _____
Race _____
Ethnicity _____
Pref. Language _____

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other
Employer _____
Phone _____

CONTACTS

Emergency Contact _____ P # _____
Nearest Relative _____ P# _____
Pharmacy _____ P# _____
Spouse _____
Spouse's Employer _____
How did you hear about us? _____

GUARANTOR

[ ]Same as Patient
Name _____
Address _____
_____
City,State _____

GUARANTOR'S EMPLOYMENT

Employer _____
Phone _____
Alt Phone _____
Social Security # _____
Date of Birth _____
Relationship to Primary Insured/Guarantor _____

PRIMARY INSURANCE

Insured is [ ] Same as Patient [ ] Same as Guarantor
[ ] Work Comp [ ] Liability
Insurance Name _____
Insurance Phone _____
Policy Holder _____

Social Security # _____
Insured ID _____
Insured's Date of Birth _____

SECONDARY INSURANCE

Insured is [ ] Same as Patient [ ] Same as Guarantor
[ ] Work Comp [ ] Liability
Insured Party _____

Relationship to Primary
Insured/Guarantor _____
Social Security # _____
Insured's Date of Birth _____

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GENERAL CONSENT FORM

Patient: _____ **DOB:** _____ **Date:**_____

I, the undersigned, agree to the following:

CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician/nurse practitioner, his assistant, designees or consultants, as may be necessary in the judgment of my physician/nurse practitioner. I also understand that I will be billed direct for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained, and authorize access to persons involved in my care.

(_____)

RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES

Oxford Orthopaedics & Sports Medicine, PLLC (the "Clinic") is not responsible for valuables, including money, jewelry, glasses, dentures, documents and other personal items.

(_____)

RELEASE FROM RESPONSIBILITY

If I should leave the Clinic against medical advice or prior treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(_____)

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, workers compensation carriers, the Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the Clinic charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic, as may be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessaiy to carry out treatment, payment or Clinic operations.

(_____)

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of Oxford Orthopaedics & Sports Medicine, PLLC's Notice of Privacy Practices. My initials acknowledge receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(_____)

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MEDICARE CERTIFICATION RELEASE

I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

ASSIGNMENT OF BENEFITS

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payors. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to, billing insurance, filing petitions, filing suit in name or on behalf of the Clinic, filing proofs or claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third Patty Payor, the patient or guarantor.

(_____)

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that I am financially responsible to the Clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self insured health plans or other third party payor are due and payable upon services based on the best estimates available as determined by the Clinic. Charges remaining on this account are payable upon demand. It is also agreed that in case of default of payment and this account is placed in the hands of a collector or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expense will be paid by the undersigned.

(_____)

NON-CERTIFICATION OF SERVICES

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the

· event the insurance denies either all or part of their payment on the Clinic account, I will pay the account in full upon demand.

(_____)

CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING

I authorize the Clinic to photograph, videotape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I understand that these original images will be stored in a secure manner. Images that identify the patient will be released and/or used outside the Clinic only upon written authorization from myself or authorized party or as assigned by law. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(_____)

I have read the above consent and various releases, assignments of benefits and agreement for payment of charges and herewith execute the same voluntarily. A copy of this document shall be valid as the original.

_____

Patient Signature (or Person Responsible and Relationship)

PATIENT IS UNABLE TO CONSENT BECAUSE: _____

_____

_____

_____ _____ _____

Witness Date Time

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FINANCIAL POLICY

Thank you for choosing Oxford Orthopaedics and Sports Medicine, PLLC (OOSM) for your orthopaedic care. We are committed to providing you with quality orthopaedic health care. Our organization's financial policy is as follows:

- Please note that you will need to present your insurance card and proof of identity (e.g. driver's license) at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs.

We accept cash, checks, MasterCard, Visa, and debit cards.
I. OOSM has provider contracts with some insurance carriers with "in-network" status.

- Insurance contracts require us to collect your co-payment at the time of service.
- Our office will assist you in receiving proper reimbursement, by filing your claim promptly and correctly.
  - > After your insurance company processes the claim, (in about 30 days) you will receive an Explanation of Benefits (EOB) from your insurance, which will show the "Patient Responsibility" amount.
  - > We will provide you with a statement showing the amount due.
  - > For large balances, you may contact our Billing Department or visit our patient portal to make payment arrangements using your credit/debit card or check.
  - **> Effective January 2012, OOSM has the capability to store your credit card information through our payment processing service, TransFirst. This will allow your future payments to be processed easily. Please indicate below your choice of having OOSM store your credit card information. Thank you for confirming your choice with the Receptionist during check-out.**

____YES, please store my credit card information _____NO, do not store my credit card information Initial _____

> You may at any time, pay your account in full.

- Individual coverage varies dramatically within our contracts and your coverage is an agreement between you and your health plan/health insurance company.
- It remains your responsibility to verify that the care you receive is covered by your health plan/health insurance.
- This office is not responsible for the expense of treatment not paid by your health plan/health insurance.
- With continuous changes in coverage, you should verify your benefits and understand all requirements of your health plan/health insurance by calling the customer service number on your health plan/health insurance card.

II. When OOSM does not have a contract with your health plan/health insurance carrier, services are "Out of Network"

- This means that you may have no insurance benefits with our clinic.
- You will be responsible for the entire amount at the time services are rendered.
- As a courtesy, we can file a claim to your health plan. Should your plan pay, you will be refunded.
- Your signature on this Financial Policy will be your acknowledgement that you are aware that your benefits will be paid as "out of network".

REVISED OCT. 2017

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FINANCIAL POLICY CONT'D

III. Motor Vehicle Accidents (MVA) & Third Party Liability

- OOSM will file claims for services provided as the result of a motor vehicle accident or third party liability injury; however, the patient will be responsible for the entire account.
- You will be required to complete a special Automobile Accident Intake form before you will be seen by the doctor.
- A prepayment will be required on the initial visit.

IV. Workers' Compensation and Independent Medical Evaluation (IME)

- Patients with authorized Workers' Compensation or scheduled for prepaid IME will not be subject to this Financial Policy.

V. No Insurance Coverage (self pay)

- The patient or guardian will be responsible for payment, which may include x-rays at the time of service. The office visit charge will be $250.00. If the charge for the visit is less than $ 250.00, OOSM will refund the difference. If the charge for the visit is more than$ 250.00, OOSM will bill the patient for the difference. If surgery is required you will be required to pay half of the estimated surgery charge before the surgery will be scheduled.

VI. Referrals

- If your health insurance requires a referral from your primary care provider (PCP) for your visit with our practice, the referral must be obtained by the patient and presented to us at the time of the visit. If you do not have the required referral from your PCP, the visit will be re-scheduled to allow time to contact your PCP and arrange for a referral.

VII. Durable Medical Equipment (DME)

- There is a wide variety of coverage for DME (i.e., braces, walker boots, etc.). Some plans cover the expense in full, some pay 80% with a 20% co-pay, others plans only cover with the appropriate rider. Some plans cover certain items of DME but not all. With all these variables, we cannot be expected to know the coverage you have in your insurance contract. It is the patient's responsibility to determine your DME benefit with your health plan. DME cannot be returned once the patient has been given it.

I understand these policies and accept responsibility for payment of my account.

Patient Name:_____ **DOB:**_____

Responsible Party Signature:_____ **Date:**_____

REVISED OCT. 2017

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Controlled Substance Medication Agreement

Patient: _____

I understand that Oxford Orthopaedics and Sports Medicine (OOSM) may prescribe a controlled substance medication as part of my treatment plan for pain management. This Controlled Substance Medication Agreement is a tool for communication allowing us to work together in good faith and for you to understand the importance of this medication. In prescribing a controlled substance medication, we must partner with our patients to create the best treatment plan for your improvement and management of pain. This requires cooperation, trust, and mutual respect. If you cannot agree with the following te1ms, we will be unable to prescribe controlled pain medication and the failure to continue to follow all terms will result in discontinuing the pain medication and/or dismissal from our practice.

I. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my Physician.

2. I will keep regularly scheduled appointments with my Physician. There may be times when your medications will need a refill between office visits. If that occurs, please call our staff at least 1 to 2 days before your medication runs out. Refill requests will only be taken on Monday-Friday from 8 am to 4 pm. In other words, any request for controlled substance pain medications after 4 pm on Fridays will not be considered for refill until Monday morning at 8 am. Your physician or an on call physician will not refill any pain medication after hours or on weekends. If you 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 your activity level of physical condition, the treatrnent may be changed or discontinued. You are responsible for notifying your physician of such changes.

4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves. If your condition does not in1prove, your Physician may recommend additional conservative or invasive orthopedic procedures. If your level of pain still does not allow you to taper and discontinue the controlled substance pain medication, you will be referred to a pain management specialist for management of your 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. You are not to accept or seek controlled substance pain medication from any other physician or health care provider outside of our practice while we are prescribing pain medication, including your primary care physician. It is essential that only one physician monitor and evaluate your use of pain medication.

7. If you have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing physician, including any pain medication for you orthopedic condition.

8. It is required that you use a single pharmacy for all prescriptions. You may use a chain of pharmacies with different branches, as the prescription infomation is available at all branches. This is required to make certain that your medications are known by a pharmacist able to evaluate any concerns about interactions of medications.

9. I understand that lost, stolen, or misplaced prescriptions or pills will not be replaced. All patients are required to act responsibly with their medications. This medication is prescribed for you and only your specific pain needs. To allow others to use your pain medication is illegal and dangerous. This type of behavior will not be tolerated by your Physician or our practice.

10. I agree that I will not use any other illegal and/or recreational drug while receiving care and pain mediation 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:**_____

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Ownership Disclosure Form

List of Alternative Suppliers of MRI, CT, and PET Scans

This notice informs you that Dr. Cooper Terry and Dr. Daniel Boyd have an ownership interest in the Baptist Memorial Hospital Imaging Services, LLC, d/b/a Oxford Diagnostic Center. Per the Patient Protection and Affordable Care Act of 2010, you must be given a formal, written notice that there exist suppliers, other than Oxford Diagnostic Center, who are located within a 25 mile radius of this facility who have the ability to provide you with the

MRI CT PET

for which you have been referred. For the purposes of this notice the term "supplier" means a physician or other practitioner, facility, or other entity that can furnish the imaging service for which you have been referred.
The alternate suppliers, within 25 miles of this facility, who are capable ofperfonning your imaging study, should you wish to have it performed elsewhere, include:

Baptist Memorial Hospital - North Mississippi
2301 S Lamar Blvd, Oxford, MS 38655
662-232-8100

Tri-Lakes Medical Center (MRI and CT)
303 Medical Center Drive, Batesville, MS 38606
662-563-5611

Yalobusha General Hospital (CT Only)
630 S Main Street, Water Valley, MS 38965
662-473-1411

Odom Rural Health Clinic (MRI Only)
604 S Main Street, Water Valley, MS 38965
662-473-4050

***Please note, this form is being provided to the patient to ensure compliance with Section 6003 of the Patient Protection and Affordable Care Act of 2010 (ACA). This form should in no way be construed as an endorsement or recommendation of the suppliers listed above. Our practice is providing this information to you based solely on the legal requirement of the ACA.*

Oxford Surgery Center

Please be informed that Dr. Cooper Terry, Dr. Daniel Boyd, and Dr. Kurre Luber have a financial interest or ownership in the Oxford Surgery Center located at 499 Azalea Drive, Oxford, Mississippi 38655.

One Source Rx Series F, LLC

During your visit with your physician today you may be given a prescription for medication. For your convenience, your prescription may be sent directly to your home by One Source Rx Series- F, LLC. Please note that Dr. Cooper Terry, Dr. Daniel Boyd, and Dr. Kurre Luber have a financial interest or ownership in One Source Rx Series-F, LLC. Should you wish to use a different pharmacy, please notify your physician or physician's staff.