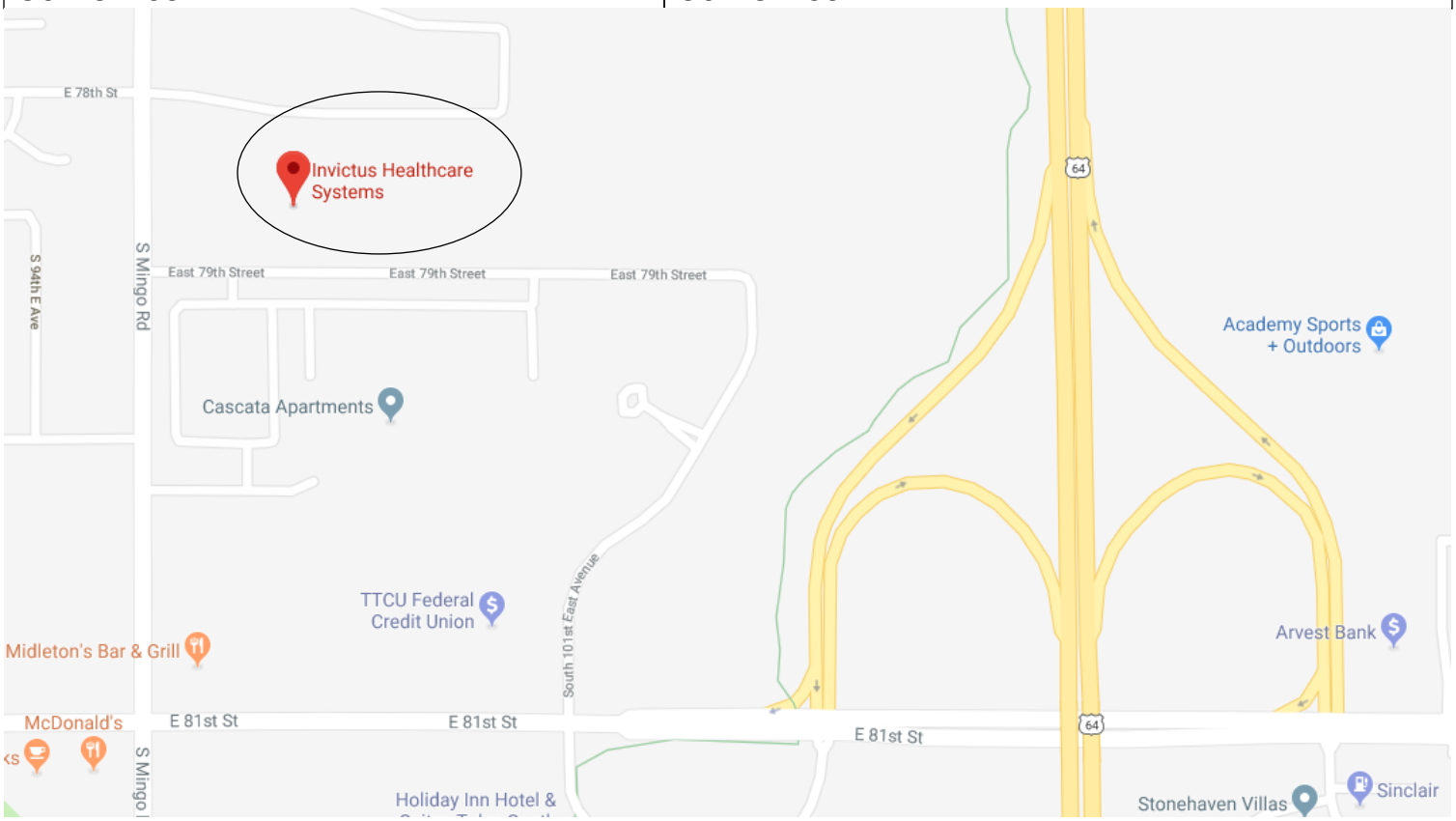
Checklist for Appointment:

Photo ID
Insurance Card(s)
List of Medications
Films
Paperwork completed
Copay, Co-insurance, Deductible due at time of service.

If you have any questions please contact the office at (918)994-4000

Directions

From the North: Take highway 169 South and exit on 81st street. Go West (right) to Mingo, turn right on to Mingo. Go North on Mingo to E. 79th St, turn right then turn left into patient parking lot and park in the back of the parking lot to enter our office.	From the East: Take highway 51/Broken Arrow Expressway to highway 169 South. Exit on 81st. Go West (right) to Mingo, turn right on to Mingo. Go North on Mingo to E. 79th St, turn right then turn left into patient parking lot and park in the back of the parking lot to enter our office.
From the South: Take Creek Turnpike to highway 169 North and exit on 81st. Go West (right) to Mingo, turn right on to Mingo. Go North on Mingo to E. 79th St, turn right then turn left into patient parking lot and park in the back of the parking lot to enter our office.	From the West: Take I-44 West to Highway 51/Broken Arrow Expressway then merge onto HWY 169 South. Then Exit onto 81st. Go West (right) to Mingo, turn right on to Mingo. Go North on Mingo to E. 79th St, turn right then turn left into patient parking lot and park in the back of the parking lot to enter our office.



9709 E 79th St -Tulsa, OK 74133
Main Office: (918) 994-4000 - Fax: (918) 994-4090

Pharmacy/Farmacia_____ **Pharmacy/Farmacia #**_____

Name/Nombre:_____
Last/Apellido **First/Nombre** **Middle/2nd Nombre** **Nickname/Apodo**

DOB/Fecha de Nacimiento: ____/_____/_____ **Gender/Genero:**_____ **Marital Status/Estado Civil:** S☐ M/C☐ D☐ W/V☐

SSN/Seguro Social #:_____**Ethnicity/Etnia:**_____**Primary Language/Lenguaje Primario:**_____

Address/Direccion:_____**City/Ciudad:**_____**State/Estado:**_____**Zip/Codigo Postal:**_____

Primary Phone/Telefono Principal #:_____**Secondary Phone/Teléfono Secundario #:**_____

Email Address/Correo Electronico:_____

Primary Physician/Doctor Principal:_____**Phone/Telefono #:**_____

How did you hear about us? Como supiste de nosotros?

- ☐ **Social Media/Medios De Comonicacion Social**
- ☐ **Radio/Radio**_____
- ☐ **Friend/Amigola**
- ☐ **Relative/Relativo**
- ☐ **Physician/Medico**_____
- ☐ **Event/Evento**_____
- ☐ **Direct Mail/Correo Directo**
- ☐ **Flyer/Folleto**
- ☐ **Previos Patient/Paciente Anterior**
- ☐ **Other/Otio**_____

Legal Guardian/Guardian Legal or/o Policy Holder/Titular de la poliza

Name/Nombre:_____**Relationship/Relacion:**_____

DOB/Fecha de Nacimiento: ____/_____/_____**SSN/Seguro Social #:**_____**Phone/Telefono #:**_____

Is this visit related to a Motor Vehicle Accident or Workers' Compensation Claim? ¿Esta vista está relacionada con un Accidente de un Vehículo de Motor o un Reclamo de Compensación de los Trabajadores? ***Yes☐ No☐***

Emergency Contact/Contacto de Emergencia:

Name/Nombre:_____**Phone/Telefono #:**_____ **Relationship/Relacion:**_____

Permission to disclose health and billing information/Permiso para divulger información de salud y facturación:

I,_____, hereby grant permission for Invictus Healthcare System to discuss or release information concerning my medical diagnosis, or information to or in my medical records, or any medical information that the aforementioned entity may have on file as t concerns me including but not limited to billing, benefit inquiries, claims, appeals, and complaints, to the following individual(s) in compliance with the required HIPPA guidelines.

Yo,_____, otorgo permiso para que Invictus Healthcare System debata o divulgue información relacionada con mi diagnóstico médico, información a/o en mi historial médico o cualquier información médica que la entidad antes mencionada pueda tener archivada, lo cual incluye, entre otros, la facturación, consultas de beneficios, reclamos, apelaciones y quejas a las siguientes personas en cumplimiento con las pautas HIPPA requeridas.

Name/Nombre:_____Relationship/Relacion:_____

Name/Nombre:_____Relationship/Relacion:_____

INVICTUS HEALTHCARE SYSTEM

9709 E 79th St -Tulsa, OK 74133
Main Office: (918) 994-4000 - Fax: (918) 994-4090

Invictus Healthcare
Financial Policy – Patient Authorization for Treatment – Release of Information

Invictus Healthcare is committed to providing high quality healthcare services to all of our patients in an ethical, professional and cost effective manner. We want to ensure that you receive the maximum allowable benefits from your medical insurance. In order to achieve this goal; we need your assistance in understanding and following our financial policy.

The financial payment policy of this practice is to collect for services at the time of the patient's visit. Payment in full is due when services are rendered. As a service to our patients, we will file claims directly to your insurance carrier if acceptable insurance identification is provided. However, co-payment, deductibles and co-insurance are due in full at the time of service. Acceptable insurance identification is defined as a valid insurance card or policy with valid driver's license.
Additionally, all services that require pre-authorization must be authorized prior to service being rendered.

- Please be sure to provide correct insurance billing information or any other change of information on each visit.
- Our fee for completing forms is $25 per form (example: FMLA, Disability, Etc). Payment in advance is required.
- We accept cash, check, money orders, Visa and MasterCard.
- Patients and Guarantors are responsible for all charges resulting from treatment provided by Invictus Healthcare.
- Returned checks will be charged to the patient's account with a service fee of $25. Returned checks not redeemed within 10 working days of written notice to the maker may be referred to the prosecutor for collection.
- Unpaid delinquent accounts will be assigned to a collection agency or attorney for collection and will be reported to the credit bureau.

Patient / Payer Categories

- **Self-pay / No Insurance** – Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our credit manager.
- **HMO Plans** – Co-payments, if required by the plan, are due prior to services being rendered. Patients are financially responsible for visits to the clinic not covered by their plan.
- **PPO Plans** – The facility will file claims directly to your PPO Insurance. Deductibles and co-insurance or co-payments are due at the time of service. Patients are financially responsible for visits to physicians not on their plans.
- **Private Medical Insurance/ Indian Health** – As a courtesy to you we will file your primary insurance. Deductibles and co-insurance are due at the time of service. Indian health patients are responsible for bringing x-ray and referral to each appointment.
- **Medicare** – Patients are responsible for their deductible and co-insurance.
- **Medicaid** – Patients are responsible for their spend down amount at the time of service.
- **Workers' Compensation** – In order for the facility to file a Workers' Compensation claim, you will need to provide us with the name of your insurance carrier, the date of your injury, claim number and attorney's name (if applicable). **We accept Oklahoma Workers Compensation only. No out of State.**
- **MVA or Other Liability Claims** –Invictus Healthcare does not file MVA or third party liability claims. Payment is due at the time services are rendered.

Authorization for Treatment – By virtue of my signature, I authorize Invictus Healthcare and any of its employees or other authorized personnel or agents to provide healthcare services to me.

Signature – By patients signature below patient represents that patient is 18 years of age or over and legally capacitated to give consent to treatment and authorize release of information.

I have thoroughly read and understand the Financial Policy of Invictus Healthcare and I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered.

_____
Signature – Patient / Guarantor Date

Please Read and Sign

Assignment of Benefits
I authorize payment of medical benefits be paid directly to Invictus Healthcare on my behalf for any services furnished.
Authorization to Release Medical Information
I authorize the release of medical information needed to determine the benefits payable for related services.

_____
Signature – Patient / Guarantor Date

HIPAA – Acknowledgement of Receipt of Notice of Privacy Practices

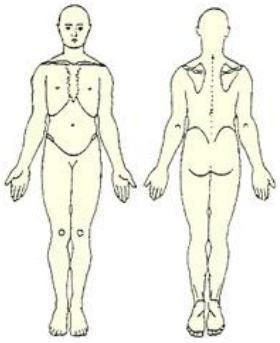
Your signature below indicates that you have received a copy of Invictus Healthcare Notice of Privacy Practices.

Printed Name of Patient _____ Signature _____

Authority to Sign if Not Patient _____ Date _____

INVICTUS HEALTHCARE SYSTEM
9709 E. 79th St – Tulsa, OK 74133
Main Office (918)994-4000 Fax (918)994-4090

Please Shade in the Areas that Hurt



Name:_____ **Date of Birth**: ____/____/____ **Age:**_____

☐**Male** **Height:** **Are you Pregnant**? ☐Yes ☐No

☐**Female** **Weight:**

Date of Injury: **Work Related:** ☐Yes ☐No

What is the reason for seeing the doctor? (Please describe the problem and symptoms)

_____

_____

If applicable, how did the injury occur? (Please be specific)_____

_____

What makes the problem better?_____

What makes the problem worse?_____

Have any tests been done? ☐X-Rays ☐CT Scan ☐MRI ☐EMG Other:_____

Have you had a previous injury to the part of your body we are seeing you for today? (Please be specific)_____

_____

What treatments have you had for this problem?_____

List all current medications (Prescription and non-prescription):_____

_____

List all Allergies:_____

_____

Are you allergic to Latex: ☐Yes ☐No

List all past surgeries (Include dates):_____

_____

List any family history of disease:_____

_____

<u>Past Medical History</u> (Have you had, or do you presently suffer from):

AIDS/HIV	☐Yes	☐No	Heart Attack	☐Yes	☐No	Seizures	☐Yes	☐No
Arthritis	☐Yes	☐No	Hepatitis	☐Yes	☐No	Sleep Apnea	☐Yes	☐No
Asthma	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Stomach Ulcers	☐Yes	☐No
Blood Clot	☐Yes	☐No	High cholesterol	☐Yes	☐No	Stroke	☐Yes	☐No
Cancer	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Chest Pain	☐Yes	☐No	Liver Disease	☐Yes	☐No	Vascular Disease	☐Yes	☐No
Depression	☐Yes	☐No	Psoriasis	☐Yes	☐No			
Diabetes	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No			

List any other medical problem not mentioned above:_____

<u>Social history</u>:

Do you Smoke? Yes No If yes how many packs per day? _____

Alcohol use? Yes No If yes how much per day? _____

Drug Use? Yes No If yes what kind, and how often? _____

Caffeine Intake? Yes No If yes how much per day? _____

<u>Review of Systems</u> (Do you currently suffer from any these symptoms):

Weight loss	☐Yes	☐No	Irregular Heart Beats	☐Yes	☐No	Rash	☐Yes	☐No
Weight gain	☐Yes	☐No	Shortness of Breath	☐Yes	☐No	Itching	☐Yes	☐No
Night Sweats	☐Yes	☐No	Wheezing	☐Yes	☐No	Loss of Balance	☐Yes	☐No
Fever	☐Yes	☐No	Cough	☐Yes	☐No	Numbness or Tingling	☐Yes	☐No
Sudden Visual loss	☐Yes	☐No	Nausea	☐Yes	☐No	Difficulty Sleeping	☐Yes	☐No
Recent Head Injury	☐Yes	☐No	Vomiting	☐Yes	☐No	Easy Bleeding	☐Yes	☐No
Lightheadedness	☐Yes	☐No	Abdominal Pain	☐Yes	☐No	Easy Bruising	☐Yes	☐No
Chest Pain	☐Yes	☐No						

List any other symptoms not mentioned above:_____

_____ _____

Patient or Guardian's Signature Date Physician Signature Date

Activities affected by pain/injury

Circle all that apply:

Walking	Bending	Raking Leaves
Sitting	Lying in bed	Gardening
Climbing Stairs	Using computer	Combing hair
Chewing	Exercising	Shaving
In/out of automobile	Sitting in recliner	In/out bathtub
Kneeling	Doing laundry	Brushing teeth
Sleeping	Making the bed	Driving
Standing	Vacuuming	Riding (passenger)
Lifting Children	Ironing	Reading
Grocery Shopping	Swimming	Carrying groceries
Playing Piano	Caring for pets	Sexual Intercourse
Cooking	Using Telephone	Washing dishes
Running	Lawn mowing	

Medication Agreement

Invictus Healthcare System understands that you may be experiencing pain, however, so we can control your pain after a major operation, we retain the right to not fill any prescription for any narcotic before your surgery.

When you call for refills, call your pharmacy and give them your prescription number that is on the bottle. PLEASE ALLOW OUR OFFCIE 24 HOURS TO RESPOND TO ALL PRESCRIPTION REQUESTS. No medication will be refilled on the weekend or during non-business hours. One telephone call is sufficient and DO NOT WAIT UNTIL YOU ARE COMPLETELY OUT OF MEDICATION BEFORE CALLING A REFILL.

I hereby attest that I have read these medication instructions, understand them, and agree to follow them while under the care of Invictus Healthcare System.

Date: _____

Patient: _____

Witness: _____

DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice and feel free to ask any questions you may have about the following information.

As a patient of Invictus Healthcare System, you may be referred to Oklahoma Surgical Hospital (OSH) for surgical, imaging and/or or other tests/procedures that your condition may warrant. OSH is a physician-owned hospital in which the physician's named below hold a minority ownership interest.

- Clint J. Basener, DO
- Gregory L. Wilson, DO

This hospital was founded in 2001 by local physicians who were determined to provide their patients with outstanding medical care in a quality environment that offered superior personalized service. Today their goal remains to provide their patients with a hospital option that allows physicians to be involved in all aspects of their healthcare delivery to insure the focus stays on quality patient care.

Please note that you have the right to choose the provider of your health care services. Therefore, you have the option to use a health facility other than Oklahoma Surgical Hospital if you choose.

You will not be treated differently if you choose to obtain health care services at a facility other than Oklahoma Surgical Hospital.

If you have any questions concerning this notice or anything in it, please feel to ask your physician or any representative here. In addition, if you would like additional information about Oklahoma Surgical Hospital's and its clinical and emergent capabilities please contact Valerie Ballenger, R.N., Chief Nursing Officer at 918-477-5091 or Rick Ferguson, Chief Executive Officer at 918-271-2756.

Thank you.

_____

Received and Acknowledged Date

DIVULGACIÓN DE LA PROPIEDAD DEL MÉDICO

Por favor revisen cuidadosamente la información contenida en este aviso y no dude en hacer cualquier pregunta que tenga sobre la siguiente información.

Como paciente del sistema de salud Invictus, usted puede referir a Hospital quirúrgico de Oklahoma (SST) para la proyección de imagen quirúrgica, o' otras pruebas o procedimientos que puede justificar su condición. OSH es un hospital de propiedad de un médico en el que el médico había nombrado a continuación mantenga un interés de propiedad de minorías.

- Clint J. Basener, hacer
- Gregory L. Wilson, hacer

Este hospital fue fundado en 2001 por los médicos locales que estaban decididos a ofrecer a sus pacientes con la atención médica excepcional en un ambiente de calidad que ofrece un servicio personalizado superior. Su objetivo sigue siendo hoy brindar a sus pacientes con una opción de hospital que permite a los médicos a participar en todos los aspectos de su atención sanitaria para asegurar que el enfoque permanece en atención de calidad.

Tenga en cuenta que usted tiene el derecho a elegir el proveedor de los servicios de salud. Por lo tanto, usted tiene la opción de utilizar un centro de salud que no sean de Oklahoma Surgical Hospital si usted elige.

Usted no sera tratado diferentemente si usted decide obtener servicios de atención médica en un centro distinto Oklahoma Surgical Hospital.

Si usted tiene alguna pregunta sobre este aviso o cualquier cosa en él, sienta por favor pregunte a su médico o algún representante aquí. Además, usted como información adicional sobre Oklahoma Surgical Hospital y sus capacidades clínicas y emergentes póngase en contacto con Valerie Ballenger, R.N., jefe de enfermería de 918-477-5091 o Rick Ferguson, Director Ejecutivo en 918-271-2756.

Gracias.

_____

Imprimir Nombre Firma y fecha