Musculoskeletal Imaging Interventional

1023 Waterwood Pkwy. Edmond, OK 73034
P: (405) 601-2325 F: (405) 497-6074

Patient Information

Patient Name: _____ DOB: ____/____/____

Email Address: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____

Employer: _____ Occupation: _____

SSN: _____ Insurance: _____ Primary Holder: _____

Primary Care Physician: _____

Referring Physician (if different from PCP): _____

Emergency Contact Information

Emergency Contact: _____

Phone: _____ Relation: _____

Authorizations

Benefits of Office:
I hereby authorize payments directly to Dr. Douglas Beall/Dr. Dan Nguyen/Legacy Medical Management, LLC for services provided. I understand that I am responsible for any portion of my bill not covered by my insurance company.

Initial: _____

Release of Information:
I hereby authorize release of information for insurance claim purposes. I hereby authorize release of information to the referring physician as well as future referrals to physicians as deemed necessary by the course of my care by Dr. Beall and/or Dr. Nguyen.

Initial: _____

HIPAA Privacy Practices:
I have read/been offered a copy of HIPAA privacy practices.

Initial: _____

I agree to the above as initialed.

Patient Signature: _____ Date: _____

Patient Questionnaire

Patient Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____

Have you had:	YES	NO
Heart Trouble/Chest Pain	☐	☐
Lung Disease (Sleep Apnea/Asthma, etc.)	☐	☐
Difficulty Breathing/Productive Cough	☐	☐
Epilepsy or Seizures	☐	☐
Jaundice	☐	☐
Hepatitis or Mononucleosis	☐	☐
PUD/Hiatal Hernia/GERD	☐	☐
Back Trouble	☐	☐
Glaucoma	☐	☐
Abnormal Bleeding Tendencies	☐	☐
Anticoagulant Therapy (blood thinners)	☐	☐
Blood Disease (anemia, etc.)	☐	☐
Kidney Disease/ Difficulty with Urination	☐	☐
Fracture of Facial Bones	☐	☐
Fracture of Neck or Back	☐	☐
Muscle Weakness	☐	☐
Paralysis/Numbness/Tingling	☐	☐
Blood Transfusion	☐	☐
Stroke	☐	☐
Blood Vessel Disease (phlebitis, etc.)	☐	☐
Diabetes: FSBS_____ Time: _____	☐	☐
Chest Xray in the past year	☐	☐
Electrocardiogram in the past year	☐	☐
Hypertension	☐	☐
DO YOU	YES	NO
Wear Dentures	☐	☐
Have loose teeth/caps/bridges	☐	☐
Wear Glasses/Contacts	☐	☐
Wear Prosthesis	☐	☐
Wear Hearing Aid	☐	☐
Do you smoke? Pck per Day_____	☐	☐
Have you ever smoked	☐	☐
Use Alcohol? Amount per day _____	☐	☐
Females: Could you be pregnant	☐	☐
Religious objection to blood transfusion	☐	☐
Have a history of substance abuse	☐	☐
Have a pacemaker	☐	☐

Time of last food or drink_____

Previous Anes History:
1. Date of last anesthetic_____
2. Any abnormal reactions
3. Relatives with abnormal reactions to anesthesia
4. Comments: _____

List previous surgeries (type and date)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all medications you are presently taking:
_____
_____
_____
_____
_____
_____
_____
_____

List Allergies/Reaction:
_____
_____
_____
_____

IV____G Location_____ Time_____ Attempts_____

Vital Signs:
Time: _____ Temp: _____ BP: _____ Pulse: _____ R: _____ O2 Sat: _____ Pain: _____

Preop RN Signature: _____

Pain / History Questionnaire, page 1

Patient Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Is your pain a result of a work-related injury? ☐ Yes (or) ☐ No

Is your pain a result of a motor vehicle accident? ☐ Yes (or) ☐ No

Date of accident or injury ☐ ____/____/_____ (or) ☐ Does Not Apply

Is there a lawsuit pending or have you hired an attorney? ☐ Yes (or) ☐ No

Name of Attorney: _____ (or) ☐ Does Not Apply

Does your pain regularly wake you from your sleep? ☐ Yes (or) ☐ No

When did your pain begin? _____

Describe the injury or cause of pain in your own words: _____

_____

_____

Please select the type(s) of pain you experience. (Check all that apply.)

☐ Constant	☐ Intermittent	☐ Periodic	☐ Frequent	☐ Occasional
☐ Burning	☐ Sharp	☐ Stabbing	☐ Dull	☐ Aching
☐ Pounding	☐ Shooting	☐ Other (Describe) _____		

Since your pain began, which of the following people have you consulted for treatment?

☐ Family Doctor/Internal Medicine	☐ Neurologist
☐ Acupuncturist	☐ Neurosurgeon
☐ Chiropractor	☐ Physical Therapist
☐ Orthopedist	☐ Occupational Therapist
☐ Psychiatrist	☐ Other: _____

Which of the following pain treatments have you tried?

Tried	Use		Tried	Use	
☐	☐	Ice/Cold	☐	☐	Brace
☐	☐	Heat	☐	☐	Psychotherapy
☐	☐	TENS Unit	☐	☐	Physical Therapy
☐	☐	Massage Therapy	☐	☐	Pain Pump
☐	☐	Exercise	☐	☐	Injections: _____
☐	☐	Spinal Cord Stimulator: ☐ Medtronic ☐ Abbott/St Jude ☐ Boston Scientific ☐ Other: _____			

Pain Indicators/Relievers

Activity	Makes Pain		Activity	Makes Pain	
Sitting	☐ Better	☐ Worse	Taking Medications	☐ Better	☐ Worse
Standing	☐ Better	☐ Worse	Applying Heat	☐ Better	☐ Worse
Lying Down	☐ Better	☐ Worse	Applying Ice	☐ Better	☐ Worse
Walking	☐ Better	☐ Worse	Massage	☐ Better	☐ Worse
Sneezing	☐ Better	☐ Worse	Pushing/pulling	☐ Better	☐ Worse
Straining/Coughing	☐ Better	☐ Worse	Bending/stooping	☐ Better	☐ Worse
Sleeping	☐ Better	☐ Worse	Other: _____	☐ Better	☐ Worse

Pain / History Questionnaire, page 2

Please list **any surgeries** that you have had in the past.

Operations	Approximate Date
1.	
2.	
3. Document on Anesthesia Questionnaire	
4.	
5.	

What diagnostic studies (X-rays, MRI's nerve studies, etc.) have you had?

****Please bring all imaging on a disk with you to your appointment. If you do not, your appointment may be rescheduled.****

Type of Study	Date	Doctor that Ordered	Location of Test
☐ Lumbar MRI			
☐ Cervical MRI			
☐ CT Scan			
☐ Myelogram			
☐ X-Ray			
☐ Bone Scan			
☐ EMG			
☐ Discogram			

Please list all medications you have tried or are currently taking.

Tried	Use	Medications (List Below)	What strength?	How often?	Since when?	Prescribed by?
☐	☐					
☐	☐					
☐	☐	Document on Anesthesia Questionnaire				
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Are you currently taking any of the following or other blood thinners? ☐No ☐Yes/ Prescribing Physician: _____

☐ Coumadin (Warfarin) ☐ Plavix (Clopidogrel) ☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Brilinta ☐ Other_____

☐ Permission to access pharmacy record

Pharmacy Name:_____ City: _____ Phone: _____

DO YOU HAVE ALLERGIC REACTIONS TO ANY MEDICATIONS? (Please provide specific side effects.)

_____

_____

Please list any other allergies	**Reaction**
☐ Latex	
☐ Tape	
☐ Dyes/Contrast Media	
☐ Other:	
☐ Other:	
☐ Other:	

Lifestyle Questionnaire

Date: _____ Name: _____

Please check all that apply:

☐ I am currently working.

☐ I am not currently working, but not due to pain problems.

☐ I am not currently working because of my pain.

☐ I am able to work, but at a reduced level and/or reduced hours because of my pain.

☐ I choose not to work.

Please describe your employment. Be specific about physical requirements and hours.

_____

_____

Please rate your pain level. (Circle appropriate number.)

(Lowest) 0 1 2 3 4 5 6 7 8 9 10 (Highest)

Have you ever had a substance abuse problem, emotional or nervous problem? ☐ Yes ☐ NoIf Yes, please elaborate.

_____

_____

_____

Have you ever seen a psychologist or psychiatrist? ☐ No ☐ Yes, please explain reason(s) and outcome.

_____

_____

_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks average? _____ ☐ Per day ☐ Per week

If no, did you drink in the past? ☐ No ☐ Yes If yes, how long since you last drank? _____

Do you drink alcohol to take away the pain? ☐ Often ☐ Sometimes ☐ Never

Do you smoke or use tobacco products? ☐ No ☐ Yes If yes, how many cigarettes or packs per day? _____

When did you start? _____ If you used to smoke, when did you quit? _____

Have you or do you smoke marijuana or use illicit drugs? ☐ No ☐ Yes

If yes, what kind and how often? _____

Do you exercise? ☐ No ☐ Yes If Yes, what type of exercise and how often?

_____

Family History

☐ Unknown

Father	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐Cancer: _____	☐Other: _____
Mother	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐Cancer: _____	☐Other: _____
Sibling 1	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐Cancer: _____	☐Other: _____
Sibling 2	☐ Hypertension	☐ Heart Attack/Stroke	☐ Diabetes Type 1/ Type 2	☐Cancer: _____	☐Other: _____

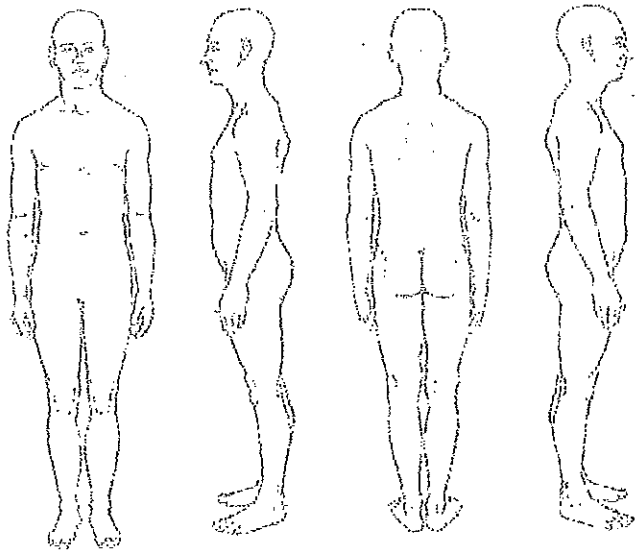
Anything else we should know to aid in your care? _____

Pain Diagram

Date: _____ Name: _____

Please mark the areas on the drawing where you feel your pain. Please use the appropriate letter(s):

N for Numbness **P** for Pins & Needles **B** for Burning **S** for Stabbing



Review of Systems

- ☐ Joint Stiffness
- ☐ Swollen Joints
- ☐ Leg Cramps
- ☐ Muscle Pain
- ☐ Muscle Cramp
- ☐ Muscle Wasting
- ☐ Back Pain
- ☐ Sciatica
- ☐ Trauma to ankle
- ☐ weakness
- ☐ Seizures
- ☐ Loss of Strength
- ☐ Balance Difficulty
- ☐ Difficulty Speaking
- ☐ Dizziness
- ☐ Paralysis
- ☐ Shortness of Breath
- ☐ Trauma to knee
- ☐ Pain in Neck
- ☐ Pain in Shoulder
- ☐ Difficulty lying flat
- ☐ Swelling in Extremities
- ☐ Cold Extremities
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Heart Attack or Stroke
- ☐ Frequent Constipation
- ☐ Frequent Diarrhea
- ☐ Blood in Stool
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Suicidal Thoughts
- ☐ Headache
- ☐

Past Medical History:

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ COPD/Emphysema
- ☐ Asthma
- ☐ Sleep Apnea: On CPAP ☐Yes ☐No
- ☐ Diabetes: ☐Type 1 ☐Type 2

Please list any additional past medical history: _____

Musculoskeletal Imaging & Interventional
Dr. Douglas P. Beall, MD
Dr. Daniel T.D. Nguyen, MD
Dr. Tyler R. Phillips, MD

Physician/Patient Treatment & Medication Agreement

I, _____ (PRINT), have agreed to report all current medications prescribed by all Physicians' involved in my care previous, present & future. In addition, I agree to take as prescribed the following medications as a part of my treatment for acute or chronic pain. I understand that these medications may not eliminate my pain but are prescribed by my Physician to reduce my daily pain in order to improve my level of activity and overall quality of life. At any given time, only one Physician is allowed to prescribe me medication for the treatment of pain. My Physician will make every attempt to prescribe my pain medication in a safe and responsible fashion. I realize that if I have a current Physician (primary or otherwise) actively involved in my care, that has been prescribing my pain medications, it may be deemed appropriate for that Physician to continue writing the prescriptions for those medications. The prescribing Physician may be contacted by our office, if necessary, to communicate our safety in prescribing policy and to determine their ability to continue or to transfer the intent of narcotic prescribing. I understand that unintentional overdose from pain medication is a problem of epidemic proportion in our country as well as worldwide. I understand that underlying health problems such as a heart or lung condition, obstructive sleep apnea, obesity, psychiatric conditions or an unanticipated infection like pneumonia can place me at higher risk for unintentional overdose. I agree that by reading and signing this treatment agreement that I will not hold Dr. Beall and/or Dr. Nguyen responsible for an unforeseen unintentional medication overdose.

Pain Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

I understand the following guidelines for interventional pain management treatment under the care of Dr. Beall and/or Dr. Nguyen may include referral to a Physician specializing in oral medication for treatment of pain management. I agree to work collaboratively with all Physicians and report current treatments interventional and otherwise to all providers.

1) I understand that I have the following responsibilities:
    a. I will take medication at the dose and frequency prescribed.
    b. I will not increase the dosage of my medications without the approval of my Physician; however, the patient can always decrease the dose or discontinue the medication if side effects occur. Don't throw the medication away until this situation is discussed with the doctor.
    c. I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends. I understand that there is a 72 hour timeframe for a prescription request to be processed and will make my requests within an appropriate timeframe to ensure that I do not run out.
    d. Excluding treatment at a hospital, I will not request any pain medications from other providers while under the care of my pain Physician and will inform this provider of all other medications I am taking.
    e. I will inform my other health care providers that I am taking these pain medications and of the existence of this agreement. In event of an emergency, I will provide the same information to emergency department providers.
    f. I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be continued or replaced. In most instances, patients will be dismissed from Dr. Beall and/or Dr. Nguyen if pain prescriptions are reported stolen. When a medication is reported stolen without police reporting, a major red flag is raised that the patient is noncompliant with treatment or associates closely with people that abuse prescription medications.
    g. I will keep medications only for my own use and will not share them with others. I will keep all medications locked in a safe and away from children.

h. I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.
i. I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities as directed by my doctor and collaborating Physicians involved in my care.

2) I will not use illegal or street drugs or another person's prescriptions. If I have an existing addiction problem or develop one while under the care of my treating Physician, I agree to inform my doctor and seek treatment. Such treatment programs may include:
   a. 12-step program and securing a sponsor
   b. Individual counseling
   c. Inpatient or outpatient treatment

3) I will do my best to keep my scheduled appointments. If I need to cancel my appointment, I will do so in advance if possible and understand that I will be charged a fee if I forget an appointment or do not notify my doctor's office at least one business day prior to the date of my appointment.

4) I understand that if my medications are adjusted, I may not be safe to drive as impairment can be present without me being aware. I will take all precautions necessary to ensure I do not put myself or others at risk during driving or other activities. I agree to drive only if fully alert and feeling clear minded without grogginess.

5) If I am prescribed a sleep medication, I agree to be in sleep position at the time the medication is taken as serious problems can occur by sleeping in poor anatomical positions for prolonged periods of time.

6) I understand that this provider may stop prescribing the certain medications listed if:
   a. I do not show my improvement in pain or my activity has not improved.
   b. I develop rapid tolerance or loss of improvement from the treatment.
   c. I develop significant side effects from the medication.
   d. My behavior is inconsistent with the responsibilities outlined above. Any of the above may result in dismissal of care.

7) I understand that pain management under the supervision and direction of my doctor with possible collaboration of other appropriate Physicians is prescribed in an appropriately aggressive fashion in order to provide the most improvement in my quality of life, trying to avoid as many side-effects possible, and with the least addictive medication/treatment regimen. I understand that medications prescribed for chronic pain could lead to an unforeseen addiction or cause a serious long-term medical condition. I recognize that there are standards of medical care that are to be followed by Physicians. In order to maximize my pain control and quality of life, my Physician may prescribe certain medications that are used "off label" or are not approved by the FDA for the treatment of my condition. I have the right to stop them immediately of course or to seek emergency treatment should side effects occur. I will not hold my Physician responsible for any medication side effects, behaviors, or problems that result from medications prescribed or treatments received in this purist of a more active lifestyle with improved pain control.

8) I understand that I will be required to perform periodic urine drug testing to monitor for compliance and/or periodic prescription pill counts. The majority of insurances cover urine drug testing, but I understand that I am still financially responsible if this service is not covered. I understand these services are necessary due to the recent scrutiny placed on all Physicians by the medical board and federal and state agencies. A medication agreement signed yearly, urine drug testing, random pill counts and regular office visits as indicated by my provider are simply tools to document patient compliance with a strategic pain management regimen. Random

pill counts and urine drug testing do not reflect a mistrust, suspicion, or discrimination toward a patient. I understand that I have a duty to notify my doctor of medication side effects, addictive cravings, or any problems associated with the care received from this office. I also acknowledge the refusal to sign this agreement will indicated that my goals of pain reduction, safety and care by these Physicians do not correlate with the goals of this practice; therefore, indicating that I choose not to be treated by this practice at this time.

Patient Signature: _____ DOB: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Provider: _____ Date: _____

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ DOB: ____/____/_____

Release of Information

☐ I authorize the release of information, including my medical and financial status with Dr. Douglas Beall. This information may be released to the following:

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell: _____.

If unable to reach me:

☐ You may leave me a detailed message.
☐ Please leave a message asking me to return your call

The best time to reach me is _____ and _____.

Medical Records

I understand that in order for my records to be released to the following person(s) listed below I, _____ have to initiate the request unless the person(s) requesting my
(Patient Name)
records have provided a copy of a Medical Power of Attorney.

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

Musculoskeletal Imaging & Interventional
Dr. Douglas P. Beall, MD
Dr. Daniel T.D. Nguyen, MD
Dr. Tyler R. Phillips, MD

Financial and Insurance Policy Agreement

Financial Policy: All Physician and practice fees are established according to services performed and payment is due when services are rendered. Should your account be referred for collections, you will incur a 21% collection fee that is based on your unpaid balance. Appointment "no-shows" or appointments not cancelled with a 24-hour notice will be subject to a $25 fee. A second "no-show" or appointment not cancelled with a 24-hour notice will be subject to a $50 fee. A third "no-show" or appointment not cancelled with a 24-hour notice will be subject to dismissal from this practice. Arriving more than 15 minutes past your scheduled appointment time could be classified as a "no-show". In the event you are late, every effort will be made to see you if time allows. Please understand that patients who have arrived on time will be seen first and you will be seen as soon as time permits.

Insurance Policy: Physicians at Musculoskeletal Imaging & Interventional may or may not be participating providers in your insurance plan. However, we will advise the insured if we are in or out of network prior to providing you or your beneficiary's care. Every attempt will be made to determine your financial responsibility; however, this is often limited by the information your insurance company will provide to us. The information provided to Musculoskeletal Imaging & Interventional will be given to you upon request.

Prior to providing elective care, Musculoskeletal Imaging & Interventional will request, verbally or in writing, a determination of benefits for the planned treatment from your insurance company. It should be constructed that this is a guarantee of coverage by your insurance company. Should the information provided by your insurance company be incorrect, financial responsibility will rest with the insured.

Specific policy language may exist in your policy that describes the manner in which multiple procedure surgery is reimbursed. This information is not routinely available to us thus making it the responsibility of the insured to check with their insurance company and provide us with that language so we can more accurately detail the financial obligations of the insured.

Companies such as Coventry and Preferred Community Choice provide network and pricing services for numerous insurance companies. We are participants in several of these networks; however, certain insurance companies within these networks fail to honor our contractual professional service reimbursement structure. In the event that this occurs, our network contract will take precedent and be utilized to determine financial responsibility. Further discounts calculated by the individual carrier will become the responsibility of the insured should our attempts to rectify the situation fail. We are providing you with this information in advance so that you understand the nature of the individual responsibilities regarding your insurance coverage.

I hereby assign all medical benefits to which I am entitled, including private insurance and other health plans to Musculoskeletal Imaging & Interventional. I authorize the release of medical information necessary to process claims for payment of services. I understand that it is my responsibility to make sure that I update all insurance information as changes occur. I understand that insurance is considered a method of reimbursement for the patient, for fees paid to the Physician, and is not a substitute of payment. I understand that the account is my responsibility to pay.

I acknowledge that I understand and agree to the financial and insurance policy agreement as stated above.

_____ _____

Signature of Patient Date