



**Nathan Overbey, MD, Brandon Valantine, DO,  
& Cooper Yates, MD.**

**14100 Parkway Commons Drive STE. #201, Oklahoma City, Oklahoma 73134**

**Office: (405) 749-2765 | Fax: (405) 749-6209**

**{ New Patient Information }**

Patients Legal Name: <u>Last</u> <u>M.I.</u> <u>First:</u>			Gender:	Date of Birth:	Age:
Patient's Address:				Soc. Sec. Number:	
City:	State:	Zip Code:	Email Address:		
Home Phone:	Cell Phone:	Work Phone:	Preferred Language:		
Race:	Emergency Contact:		Phone # of Emergency Contact:		
Marital Status: (please circle one) <b>Single</b> <b>Divorced</b> <b>Married</b> <b>Widowed</b>					
Primary Care Physician			Cardiologist (if applicable):		
Advanced Directive (check all that applies)					
Living Will      Healthcare POA      DNR      None					

Primary Insurance Carrier and Policy Number: _____
Policy Holder: _____
Relationship to the Patient: _____ Carrier's SS# _____ Carrier's DOB: _____
Secondary Insurance Carrier: _____
Relationship to the Patient: _____ Carrier's SS# _____ Carrier's DOB: _____

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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**OSH Pain Management**

**14100 Parkway Commons Drive STE. #201, Oklahoma City, Oklahoma 73134**

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{New Patient Packet}

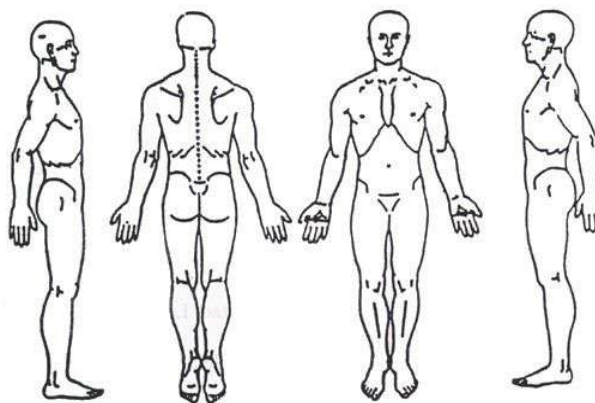
Name: \_\_\_\_\_ | DOB: \_\_\_\_\_ | Age: \_\_\_\_\_

What is your pain score for today? Please circle below:

1 2 3 4 5 6 7 8 9 10

Rate pain on a scale from 0(no pain) to 10(excruciating):

At **WORST**: \_\_\_\_\_ At **LEAST**: \_\_\_\_\_ On **Average**: \_\_\_\_\_



**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Please circle all that apply:**

Please circle the area of pain above

Is your pain constant? **YES** or **NO**

When did your pain start? \_\_\_\_\_

Is this due to a work injury? \_\_\_\_\_ Date of Injury? \_\_\_\_\_

Is this due to Motor Vehicle Accident or Personal Injury? \_\_\_\_\_ Date of Injury? \_\_\_\_\_

{Describing your pain} **Aching Dull Burning Throbbing Sharp Stabbing Shooting Pressure Squeezing Tightness**

**Cramping Spasming Pins and Needles Numbness Tingling Weakness**

{What makes your pain worse?} **Lifting Bending Squatting Stooping Twisting Sitting Standing Walking Driving**

**Reaching Looking-up Exercise/Increased-Activity House/Yard-work Coughing**

{What makes your pain better?} **Ice Heat Massage Rest Lying-down Sitting Standing/Walking Change-of-position**

**Medications Stretching Manipulation/Chiropractor Physical Therapy TENS Acupuncture**

Have you ever done physical therapy for this problem? **YES** or **NO** If yes, when? \_\_\_\_\_

Do you use any aids to better assist you when walking? \_\_\_\_\_

What medications have you tried for your pain? \_\_\_\_\_

Please list other previous treatments for your pain (i.e. injections, nerve blocks, TENS units, acupuncture, chiropractic care, surgery, or stimulator). \_\_\_\_\_

Do you have any bowel or bladder incontinence, fever chills? **YES** or **NO**

Do you currently have any allergies? \_\_\_\_\_

**PLEASE LIST:**

Medical Problems (Please circle all that apply)

Hypertension	Diabetes	Stroke	Coronary Artery Disease
COPD	Sleep Apnea	Seizures	Atrial Fibrillation
Other _____			

Surgical History: (type of surgery, date, and Surgeon): \_\_\_\_\_

**Are we authorized to view your online medication history?** YES or NO

If yes, please list current over the counter medications. If no, please list all medications:

Do you currently take any blood thinners or aspirin? **YES** or **NO** (If so what type?) \_\_\_\_\_

**Social History:**

Social status: **Married** **Single** **Divorced** **Widowed**

Do you drink alcohol? (please circle one) **No** **Occasionally** **Socially** **Frequently**

Do you smoke/vape? (please circle one) **YES** or **NO**

History of alcohol or drug abuse? **YES** or **NO**

Employment Status: **Employed** **Self-employed** **Unemployed** **Retired** **Disabled**

Use of Medical marijuana and/or recreational **Yes** or **No**

**Family History:**

Father: Medical Problems: \_\_\_\_\_

Mother: Medical Problems: \_\_\_\_\_

**Review of Symptoms: (CIRCLE ALL THAT APPLY)**

**Constitutional:** Fever, Fatigue, Weight gain, Weight loss, Generalized weakness

**HEENT:** headache, dizziness, loss of vision, corrective lenses, blurry vision, hearing loss, sinus problems, sore throat, hoarseness

**Respiratory:** Shortness of breath, Wheezing, Cough, Sleep apnea

**Cardiovascular:** Chest pain, Blood Clots, Irregular heartbeat, Feet swelling

**Gastrointestinal:** Abdominal Pain, Heartburn, Frequent constipation,

**Genitourinary:** Infections, difficulty urinating, diminished ability to control urine, urinary infection

**Musculoskeletal:** Muscle weakness, Muscle pain or tenderness, Joint pain, Joint stiffness, Joint swelling

**Neurological:** Trouble walking, Fainting spells, Memory loss, Tremors

**Psychiatric:** Anxiety, Depression, Sleeping difficulty

**Endocrine:** Excessive thirst, Excessive urination

**Hematologic:** Anemia, Easy bruising or bleeding

**Skin:** Itching, Rashes, Sores

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**Signature**

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**Date**

**Nathan Overbey, MD, Brandon Valantine, DO,  
& Cooper Yates, MD.**

**FINANCIAL POLICY**

In the interest of good business practice, the desire to continue to provide quality health services and to maintain fiscal responsibility, Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD has developed the following policy for payment of medical services:

**PAYMENT:** For all services, payment is due at the time of service. This includes co-pays, and services insurance companies will not cover. If there is a question as to whether you should make a payment, please check with the office staff.

**INSURANCE:** Our office will file insurance claims for all covered services within 2-3 business days of the visit. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance company's maximum allowable reimbursement. You will be responsible for any deductible or co-payment amounts and any non-covered services incurred at the time of service. If an insurance company fails to respond, you will be responsible for payment and can file the claim directly with the insurance company. It is your responsibility to know the benefits and conditions of your insurance plan. We file your secondary insurance company as a courtesy. If your secondary insurance has not paid within 60 days of the primary payment, you will receive a statement, and you are responsible for the balance. If the secondary insurance pays at a later date, the billing office will issue a refund to the patient.

**WORKER'S COMPENSATION:** I understand that by signing this, I will have no out of pocket expenses at this time for the approved ailment. This agreement remains in effect until the settlement of the case.

**PAYMENT PLANS:** Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates MD, has contracted with On-Pointe (for commercial insurance) to collect all outstanding balances following payment by insurer. The billing office is willing to set up payment plans if needed. If payments are missed for two (2) consecutive months, your account will be turned to an outside collection agency.

**COLLECTIONS** If your account had to be sent to a collection agency, additional fees will be incurred. Due to the cost associated with setting up the account, we will add an additional fee to your account. These charges, along with your balance, will be your responsibility in full. No additional visits will be scheduled until the account has been cleared by the collection agency.

**Motor Vehicle/ Personal Injury Accident Insurance Agreement:** *If your injuries are a result of a Motor Vehicle Accident or Personal Injury Accident, then the below applies to you.*

In order that I do not have to pay the co-pay and/or deductible associated with my personal medical insurance, I am instructing my doctor: Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD to bill the third-party liability insurance carrier and/or my personal automobile insurance med pay and/or uninsured motorist coverage (if a claim was made) listed on the Accident Information Sheet that I have signed. I understand that by doing this, I will have no out of pocket expenses at this time. This agreement remains in effect until the settlement of the case.

I also understand that a physician's lien will be filed against the third-party liability insurance/personal med-pay or U.M. associated with the case. Upon payment in full the lien will be released.

**I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OUTLINED ABOVE.**

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Patient Signature

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Date

**Nathan Overbey, MD, Brandon Valantine, DO,  
& Cooper Yates, MD.**

**Disclosure of Ownership**

Many physicians have large investment relationships or are directly employed by major health organizations in Oklahoma.

Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD are obligated to inform you they have ownership of Oklahoma Spine Hospital or any of its affiliates.

Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD make referrals to providers based on the needs of the patient and the medical standard of care in order to provide quality health care to their patients. You have the right to choose the provider for your health care services. Therefore, you have the option to use a health care facility other than the ones listed above. You will not be treated differently by the doctors or their staff if you choose another facility. If you desire, information can be provided about alternative providers.

If you have any questions regarding the information contained in the Disclosure of Ownership, please feel free to ask your physician or a representative of Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD. We welcome you as a patient and value our relationship with you.

**ACKNOWLEDGEMENT OF DISCLOSURE**

By signing the acknowledgement of disclosure, you acknowledge that you have read and understand the Disclosure of Ownership.

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Patient Signature

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Date

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Authorization to Release Information via Phone/Family/Friends

Print your name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize confidential communications from the physicians or staff of this office regarding my healthcare, lab work, test results, treatments, appointments, prescriptions, etc... to be received at any of the phone numbers listed below. I authorize to receive appointment text reminders. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Do not fill in numbers at which you do **NOT** wish to be contacted on

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

I authorize the following individuals (spouse, family members, and/or friend) to call the office on my behalf to verify the status of appointments, treatment plan, medications, and/or account information. These individuals may also pick up prescriptions and/or samples that I have requested. (Leave blank if you do not authorize any other individual to access your protected health information)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Below is the pharmacy name and phone number that I will use for all prescriptions

Pharmacy Name: \_\_\_\_\_ Pharmacy #: \_\_\_\_\_

I understand this authorization will remain in effect until I revoke the authorization in writing.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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## **Privacy Policy**

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.

It is the policy of Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD to keep all of your medical and personal information confidential. We will only use or disclose your information for the following reasons:

**Treatment:** We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others.

**Payment and or Authorization of a procedure:** We may use and disclose personal health information (PHI) when it is needed to receive payment for services provided to you. For example, if you your insurance require certain dictations or office notes to determine if a procedure is deemed necessary.

**Health Care Operations:** We will use and disclose PHI when it is needed to make sure we are providing you with good service. For instance, we may review your records in order to make certain quality services were given.

Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD may contact you to provide appointment reminders.

Other uses or disclosures of your PHI that may occur include:

-- If you have given us permission in writing to release part or all of your information. –

- When ordered to do so by a valid court order.

-- When business associates of Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD, sign agreements to protect your privacy.

-- When required by state law. For instance, when reporting injuries and disease as required by the Public Health codes or to prevent the spread of disease such as tuberculosis (TB)

-- We can share your information with anyone as necessary; consistent with Oklahoma Law and the Oklahoma State Department of Health's policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

**Emergency Coordination:** We will share your medical information with other medical providers who are involved in your care to coordinate your care with others (such as emergency relief workers or others who can help in finding you appropriate health services).

Under any circumstance other than those listed above, Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD will ask for your written authorization before we use or disclose your PHI. Specifically, Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD must obtain your written authorization for the use and disclosure of psychotherapy notes, marketing, and the sale of PHI.

Nathan Overbey, MD, Brandon Valantine, DO, and Cooper Yates, MD will not sell PHI without your written authorization.

You can later cancel your authorization in writing and we will not disclose your PHI after we receive your cancellation, except for disclosure which we process before we received your cancellation. Your Rights:

You have the right to:

- Receive of persons or organizations, other than those listed above, to whom we release your information.
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits unless you pay out of pocket in full for a service. If you pay out pocket in full for a service and you request, we not share information for that service with your insurance company we will honor your request.
  - Ask that we not contact you at home.
- Inspect and copy your medical records except in cases involving certain psychotherapy notes.
  - Amend incorrect information in your medical record.
  - Revoke your written permission for release of information.
- Receive notification if your unsecured health information is breached
  - Receive a paper copy of this privacy notice.

Our Responsibilities:

Federal law requires that Nathan Overbey, MD, Brandon Valantine, DO, & Cooper Yates, MD and its entities to:

- Maintain the confidentiality of your protected health information.
  - Provide you with a copy of this notice.
    - Abide by the terms of this notice
  - Only change this notice as permitted by federal rules.
- Provide you with a way to file complaints regarding privacy issues.

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## **Office Policies and Procedures**

**Office Hours:** Our regular office hours are Monday – Friday 8:00 – 4:30. Our phones are from 8:00 – 12:00 and 1:00 – 5:00pm. We close for all major holidays and occasionally close early due to staff meetings.

**Phone Messages and Refill Requests:** Due to the volume of calls we receive, we ask each patient to comply with our policy regarding medication refills and phone calls to the office. All urgent medical calls will be returned same day, all other may take 24 hours to process. To request a medication refill, please contact your pharmacy and have them fax a request to 405-749-6209. Medication refills will be completed within 24 – 48 business hours of the request. If the prescription must be hand written, leave a detailed message and you will be contacted when it is complete.

**After Hours Emergency:** For a true medical emergency call 911 immediately or proceed to the nearest emergency room. We do have an answering service available for urgent reasons. The answering service cannot process scheduling questions, medication refills, and/or cancellations. The answering service is intended only for urgent medical issues.

**Confidentiality:** If you have a family member or friend who you would like us to release information to (including appointment times) we need to have them on your Authorization to Treat form.

**Medical Records:** We are happy to provide you with a hard copy of your records upon receipt of the proper request form. The charge will be \$1.00 for the first page and .50 cents for each additional page. Please allow 10 days for your request to be processed.