OKLAHOMA HEART HOSPITAL PHYSICIANS

Follow up Appointment Review

Name_____ DOB _____ Date_____

Who is your Primary Care Physician? _____Reason for Visit Today_____

Pharmacy Name, Location, and Phone Number_____

Since your last visit with us have you experienced any…			**Describe changes below:**
Medication changes	☐ YES	☐ NO	_____
New drug or latex allergies	☐ YES	☐ NO	_____
Lab work	☐ YES	☐ NO	When_____
Hospitalization or ER visit	☐ YES	☐ NO	When_____ Where_____
Surgical procedures	☐ YES	☐ NO	Type_____ Where_____
New illnesses	☐ YES	☐ NO	_____
Family history illness changes	☐ YES	☐ NO	_____
Do you use oxygen?	☐ YES	☐ NO	If yes, how often ☐ As Needed ☐ Continuous ☐ At Bedtime
Do you use CPAP?	☐ YES	☐ NO	If yes, how often ☐ Occasionally ☐ Every Night ☐ With Naps

Smoking Status:

- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Heavy Cigar/Pipe Smoker
- ☐ Light Cigar/Pipe Smoker

Type of Tobacco:

- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Chewing Tobacco
- ☐ Vapor/E-Cigarettes
- ☐ Snuff
- ☐ Smokeless Tobacco/Other

Review of Systems:

Please check any of the symptoms you are currently experiencing. Any unchecked boxes will be assumed to be negative. Please check here if you are not experiencing any of the below symptoms: ☐

Constitutional
_____ Fatigue
_____ Fever
_____ Insomnia
_____ Weight gain
_____ Weight loss

Head/Neck
_____ Headache
_____ Neck Pain

Eyes
_____ Blurred vision
_____ Decreased vision
_____ Glaucoma
_____ Cataracts

Ear, Nose, Mouth, and Throat
_____ Earache
_____ Nasal Congestion
_____ Sore throat
_____ Ringing in ears

Cardiovascular
_____ Chest pain
_____ Pain in legs with walking
_____ Decreased exercise tolerance
_____ Palpitation

Pulmonary
_____ Cough
_____ Shortness of breath
_____ Snoring
_____ Sputum production
_____ Wheezing

Gastrointestinal
_____ Abdominal pain
_____ Constipation
_____ Diarrhea
_____ Heartburn
_____ Blood in stools
_____ Loss of appetite
_____ Nausea
_____ Vomiting

Genitourinary
_____ Pain on urination
_____ Urinary frequency
_____ Incontinence
_____ Frequent urination at night
_____ Urinary hesitancy

Musculoskeletal
_____ Back pain
_____ Foot pain
_____ Joint pain/stiffness
_____ Hip pain

Neurologic
_____ Confusion
_____ Lightheaded
_____ Loss of balance/coordination
_____ Slurred speech
_____ Passing out
_____ Weakness

Psychiatric
_____ Anxiety
_____ Depression

Peripheral Vascular Disease

Do you experience aching or cramping in your legs, thighs, or buttocks when walking or exercising?	☐ YES	☐ NO		
If yes, does the pain go away with rest?	☐ YES	☐ NO		
Do you have open sores or ulcers on your leg(s) or feet that will not heal?	☐ YES	☐ NO		
Do you suffer from varicose veins/spider veins?	☐ None	☐ Some	☐ Moderate	☐ Severe
Do you wear compression stockings?	☐ None	☐ Intermittent	☐ Daily	

Comments _____

Form Revision #	Form Changes
OHHP-F584 (R. 1/15)	Added Questions
OHHP-F584 (R. 4/15)	Added Peripheral Questions

Patient Name: _____

Admission Date: _____

MRN: _____

CONDITIONS OF ADMISSION

Assignment of Insurance Benefits: I hereby authorize payments from all insurance companies to be made directly to **OKLAHOMA HEART HOSPITAL, LLC** or **OKLAHOMA HEART HOSPITAL SOUTH, LLC**, hereinafter referred to as **"OHH,"** and **OHH PHYSICIANS, LLC**, hereinafter referred to as **"OHHP,"** for benefits otherwise payable to me. I understand that I am financially responsible to the hospital for charges not covered by this assignment. I certify that the above information in support of this claim is true and correct.

Medical and Surgical Consent: The patient, or his or her representative, hereby acknowledges the patient's need for hospitalization or treatment because he or she suffers from a condition requiring diagnosis and medical and/or surgical treatment. The undersigned requests and voluntarily consents to the patient's receipt of the usual Hospital services, as well as the diagnostic laboratory (such as testing of the blood and other bodily fluids), x-ray procedures, medical and/or surgical treatment, including administration of anesthesia judged to be necessary by the patient's attending physician, his assistants or other physicians designated by him. The Hospital is authorized to retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience any specimens or tissue removed from the patient's body during hospitalization or treatment.

Payment Responsibility: The undersigned understands that the patient, or another person who specifically agrees to guarantee payment for the patient, is responsible for the payment of all charges of the Hospital or Physician relating to services rendered by the Hospital or Physician to the patient that exceed any third party coverage, including applicable coinsurance payments and deductibles and all amounts for which payment has been denied by any third party. There are other services that will be billed separately from the hospital bill including services performed by other physician specialists who perform services for your care and treatment while a patient at OHH. Amounts due from the patient to the Hospital prior to execution of this Agreement may, at the sole discretion of the Hospital, be consolidated with, and made a part of, the amount due hereunder. The patient shall pay all costs of collection in connection with the enforcement of this commitment, including reasonable attorney's fees and court costs incurred by the Hospital. You authorize personal contact from us or our third-party collector, via telephone or cell phone numbers provided to us, including line voice, text, auto dialed or prerecorded message.

Other Uses of PHI: I understand that in-hospital staff committees may utilize data relating to my condition in the course of studies for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality. I understand that should the recipients use or publish such information or material that my identity shall be confidential and shall not be revealed under any circumstances.

Provider Based Billing: When seeing an OHH healthcare provider for any type of outpatient services, you will see a change in the way you are billed. Under "Provider Based" status, OHH is required to bill provider services in two parts. When your medical services are completed, OHHP will submit a claim for the professional fee and OHH will submit a claim for the facility fee. You will receive two statements/bills for your services – one from OHH and one from OHHP. ☐ **N/A**

_____ **(Initial)** I acknowledge receipt of the Provider Based Medicare Outpatient Coinsurance Notice; actual liability will depend on services furnished. ☐ **N/A**

Notification of HIV Testing: The undersigned has been notified of the testing of the patient's blood for human immunodeficiency virus (also known as AIDS) if determined by the patient's attending physician. This is necessary (i) for determining the appropriate treatment and/or treatment procedures for the patient or (ii) for the protection of the attending physician and/or any employee or agent of the Hospital or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease. _____ **(Initial)**

Facility Directory: Unless I object, I understand that my name, location, general condition, and religious affiliations may be released to the clergy or to others who ask for me by name. ☐ **Agree** ☐ **Object** (If I object, I understand I cannot receive phone calls, deliveries, etc.)_____**(Initial)**

Acknowledgment of Notice of Privacy Practices: I have received/reviewed the "Notice of Privacy Practices" from OHH. If I have any questions, I know to contact the Privacy Officer whose information is provided to me in the "Notice of Privacy Practices". I understand that if I request a copy of this form one will be provided to me by the Registration staff. _____ **(Initial)**

Disclosure of Physician Interest: OHH has financial relationships with numerous Oklahoma physicians, some of whom have an ownership interest in the Hospital, and some of whom are paid by the Hospital for services they provide. If the physician who recommended the Hospital to you has a financial interest, and if his or her financial relationship with the Hospital concerns you, you may be treated at an alternative facility, if there is one available. If you would like to discuss your options for treatment at other facilities, or if you have any questions about this disclosure, please ask the person providing you with this form for assistance. A list of physician owners has been provided to me. _____**(Initial)**

Electronic Messages Consent: Your health is important to OHH. In order to provide you with the best possible care, OHH, its agents or affiliates may contact you with marketing information, health information, appointment reminders, billing, collections, and other account activities by **telephone, autodialed calls, text, email, robocalls, and artificial, prerecorded voices, and other electronic messages**. It is not possible to guarantee that any transfer of information over text messaging is 100% secure. As a result, OHH cannot guarantee the absolute security of information sent via text message. By permitting OHH to transmit information to you through text messaging, you accept the risk that the transmission is not secure, and that your information may be exposed to a third party. Text message and data rates may apply to messages sent by OHH and multiple texts may be sent each day. I ☐ **Agree** ☐ **Object** to receiving text message and other electronic messages sent by OHH or third parties on OHH's behalf. I understand that I can op-out of texting at any time by replying STOP to any text message sent by OHH or a third party on behalf of OHH.

THE UNDERSIGNED CERTIFIES THAT SHE/HE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

_____ _____

Date Patient, Patient's Agent or Representative

_____ _____

Witness Agent or Representative's Relationship to patient

Date & Version #	Change Summary
07/30/2020 Ver 9	Added Text Consent
08/26/2020 Ver 10	Multiple Changes

Stop!

If you are on Medicare or 65 years of age or older, please complete the next form.

If you are not on Medicare and less than 65 years of age, please stop here.

OKLAHOMA HEART HOSPITAL | OKLAHOMA HEART HOSPITAL PHYSICIANS

Patient Name:_____

Admission Date:_____DOB:_____

MSP Questionnaire

PART I

1. Are you currently enrolled in a SNF or Hospice facility?

   ☐ Yes. What is the name, address and phone number of the facility?
   Name: _____Address:_____Phone:_____
   _____

   ☐ No.

2. Are you receiving Black Lung (BL) Benefits?

   ☐ Yes. Date benefits began: ____/____/____ MM/DD/YY
   (Staff only: BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.)
   ☐ No.

3. Are the services to be paid by a government research program?

   ☐ Yes. **(Staff only: GOVERNMENT PROGRAMS WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.)**
   ☐ No.

4. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

   ☐ Yes**. (Staff only: DVA IS PRIMARY FOR THESE SERVICES.)**
   ☐ No.

5. Was the illness/injury due to a work-related accident/condition?

   ☐ Yes. Date of injury/illness: ____/____/____ MM/DD/YY
   Patient: IF YES, GO TO PART III AND CONTINUE.
   (Staff only: WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS.)
   ☐ No.

PART II

1. Was the illness/injury related to a non-work related accident?

   ☐ Yes. Date of injury/illness: ____/____/____ MM/DD/YY
   ☐ No. P**atient: IF NO, GO TO PART III.**

2. Is no-fault insurance available?

   ☐ Yes. **Patient: IF YES, GO TO PART III AND CONTINUE.**
   (Staff only: WE DO NOT FILE NO-FAULT INSURANCE. PATIENT WILL BE SELF PAY.)
   ☐ No.

3. Is liability insurance available?

   ☐ Yes. **(Staff only: WE DO NOT FILE LIABILITY INSURANCE. PATIENT WILL BE SELF PAY.)**
   ☐ No.

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Patient Name:_____

PART III

1. Are you entitled to Medicare based on:

   ☐ Age **Patient: COMPLETE PART IV ONLY.**
   ☐ Disability **Patient: COMPLETE PART V ONLY.**
   ☐ End-Stage Renal Disease (ESRD) **Patient: COMPLETE PART VI ONLY.**

PART IV - Age

1. Are you currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

2. Is your spouse currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

   Patient: IF NO TO BOTH QUESTIONS 1 AND 2, STOP. DO NOT PROCEED. **(Staff: MEDICARE IS PRIMARY.)**
   Patient: IF YES TO QUESTIONS 1 AND 2, CONTINUE.

3. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

   ☐ Yes, both. ☐ Yes, self. ☐ Yes, spouse.

   ☐ No.

4. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

   ☐ Yes.
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

5. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

6. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS 1 OR 2.)**

OKLAHOMA HEART HOSPITAL | OKLAHOMA HEART HOSPITAL PHYSICIANS

Patient Name:_____

PART V - Disability

1. Are you currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed. ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY

2. Do you have a spouse who is currently employed?

   ☐ Yes. ☐ No. ☐ No, never employed.

   ☐ No, retired. Date of retirement: ____/____/____ MM/DD/YY
   Patient: IF NO TO BOTH QUESTIONS 1 AND 2, STOP. DO NOT PROCEED. (Staff: MEDICARE IS PRIMARY.)
   Patient: IF YES TO QUESTIONS 1 AND 2, CONTINUE.

3. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

   ☐ Yes, both. ☐ Yes, self. ☐ Yes, spouse.

   ☐ No.

4. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

   ☐ Yes.
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

5. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

6. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

PART VI – End-Stage Renal Disease (ESRD)

1. Do you have a Group Health Plan (GHP) coverage based on your own or your spouse's current/former employment?

   ☐ Yes.
   ☐ No.

2. Are you covered under the Group Health Plan (GHP) of a family member other than your spouse?

   ☐ Yes.
   ☐ No. **(Staff: MEDICARE IS PRIMARY.)**

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Patient Name:_____

PART VI – End-Stage Renal Disease (ESRD) Continued

3. Does the employer that sponsors the patient's Group Health Plan (GHP) employ 20 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

4. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes. **(Staff: GROUP HEALTH PLAN IS PRIMARY.)**
   ☐ No. **(Staff: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.)**

5. Have you ever received a kidney transplant?

   ☐ Yes. Date of transplant: ____/____/____ MM/DD/YY
   ☐ No.

6. Have you received maintenance dialysis treatments?

   ☐ Yes. Date of maintenance: ____/____/____ MM/DD/YY
   ☐ No.

7. Are you within the 30-month coordination period?

   ☐ Yes. Date coordination period began: ____/____/____ MM/DD/YY
   ☐ No. **Patient: STOP. DO NOT PROCEED.** **(Staff: MEDICARE IS PRIMARY.)**

8. Are you entitled to Medicare on the basis of either (ESRD and AGE) or (ESRD and DISABILITY)?

   ☐ Yes.
   ☐ No. **(Staff: GHP IS PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.)**

9. Was the initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

   ☐ Yes. **(Staff: GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.)**
   ☐ No. **(Staff: INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.)**

10. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

    ☐ Yes. **(Staff: GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.)**
    ☐ No. **(Staff: MEDICARE CONTINUES TO PAY PRIMARY.)**

Date & Version #	Change Summary
01/18/2014 Ver. 1	Original
04/22/2015 Ver 2	Updated SNF info
05/21/2015 Ver 3	Pt. approach created

Effective: 5/7/08