Invictus Healthcare System
9709 E 79th St Tulsa, OK 74133
Phone: 918-994-4000
Fax: 918-994-4090

Established Patient Forms

Patient Information

Patient Name		Date of Birth	Today's Date
SSN ☐ Male ☐Female	Height _____ Weight _____	Marital Status ☐ Divorced ☐ Domestic Partner ☐ Single ☐Married ☐ Separated ☐ Widowed	Employer
Street Address, City, State, Zip		Email **Required*	
Primary Phone ☐ Able to receive text messages		Preferred Contact Method ☐ Text ☐ Phone ☐ Email ☐ Other: _____	
How did you hear about our office?			

Insurance

Primary	_____	ID#	_____	Policy Holder	_____	DOB	_____
Secondary	_____	ID#	_____	Policy Holder	_____	DOB	_____

Responsible Party ☐ Self

Legal Name (Last, First, Middle)	DOB	Relationship to Patient ☐ Parent ☐ Spouse ☐ Other: _____
Address	SSN	Primary Phone ☐ Able to receive text messages

Emergency Contact

Legal Name (Last, First, Middle)	Relationship to Patient ☐ Parent ☐ Spouse ☐ Other: _____	Employer
Address ☐ Check here if same as above	Primary Phone	☐ Home ☐ Mobile ☐ Other: _____

Coordination of Care *Please provide the provider's first and last name and/or clinic.*

Primary Care Provider	Referring Provider	Cardiologist
Neurologist	Nephrologist	Other

Preferred Local Pharmacy

Name	_____	Location	_____
Phone	_____	Fax	_____

INVICTUS HEALTHCARE SYSTEM

Patient Name: _____ DOB: _____

Medical/Social History

List *medical conditions* diagnosed since your last visit with us.
List *operations* performed since your last visit with us.
Do you fall frequently?
Do you smoke cigarettes?

Screenings *Please list the date and results (if known and applicable).*

Bone Density Scan Date _____ Result_____	Colonoscopy Date _____ Result_____	Mammogram Date _____ Result_____
☐ MRI / ☐ CT Date _____ Result_____	Labs- Specify _____ Date _____ Result_____	Other- Specify _____ Date _____ Result_____

Current Medications *Include over-the-counter medications and supplements.* ☐ Check box *if NO* medications.

Drug Name	Dosage Strength (i.e., mg/mcg)	How many times a day?
1.		
2.		
3.		
4.		
Attach an additional list if there are more medications.		

Allergies ☐ *Check box if there are NO medication allergies.*

Drug Name / Drug Class / Food	Reaction	Severity
1.		
2.		
3.		
Attach an additional list if there are more allergies.		

Today's Visit

Briefly describe your reason for seeing the provider today.
If applicable, how did the injury occur?
What words best describe your pain?
Activities affected by pain/injury?
What helps/eases the pain?

Patient Name: _____ DOB: _____

MEDICATION AGREEMENT

Invictus Healthcare System understands that you may be experiencing pain. However, in order to control your pain after a major operation, we do retain the right NOT to fill any prescription for any narcotic before your surgery.

Refill requests:

- To avoid delays, please initiate refill requests 3 business days prior to being out of medication. Do NOT wait until you are out of medication.
- To initiate a refill request, please contact your pharmacy and provide them with the prescription number listed on the bottle of your last prescription.
- PLEASE ALLOW OUR OFFICE 24 HOURS TO PROCESS/RESPOND TO PRESCRIPTION REQUESTS.
- Medication refills are only addressed during office business hours, Mon-Thur 8am-5pm and Fri 8am-12pm.
- To follow up on refill requests, please contact your pharmacy first. If your insurance requires a prior authorization or there is an issue the pharmacy can not address, please contact our office at that time.

AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

Many of our patients allow family members such as their spouse, parent, adult children or others to call and request medical, scheduling, and/or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to allow your medical, scheduling, and/or billing information to be released to family members, you must sign this form.

Signing this form will only give information to the individual(s) indicated below. I understand that I may cancel this consent at any time (in writing to Invictus Healthcare System), but that canceling it will not affect any information that has already been released. I understand that information disclosed to any recipients listed below is no longer protected by federal or state law and may be subject to disclosure by the recipient. I authorize Invictus Healthcare System to release my medical, scheduling, and/or billing information to the following:

Name _____ Relation _____ Phone Number _____

Name _____ Relation _____ Phone Number _____

FINANCIAL POLICY & AUTHORIZATION FOR TREATMENT

Invictus Healthcare is committed to providing high quality healthcare services to all of our patients in an ethical and cost effective manner. To achieve this goal, we need your assistance by understanding and following our financial policy. Signing this form indicates you understand the financial payment policy of this practice is to collect for services in full at the time of the patient's visit and the following:

- We accept cash, check, money orders, Visa and MasterCard.
- Co-payment, deductibles and coinsurance are due in full at the time of service.
- Please provide correct billing information or any other change of information when checking in for each visit.
- All services that require pre-authorization must be authorized prior to service being rendered.
- $50 no-show fee is applied for office visits and $75 no-show fee is applied for procedural visits that are canceled or rescheduled within 24 hours of the appointment time.
- $25 form completion fee is required in advance (example: FMLA, Disability, Etc).
- Patients and Guarantors are responsible for all charges resulting from treatment provided by Invictus Healthcare.
- Indian Health patients are responsible for bringing x-ray and referral to each appointment.
- In regard to Workers' Compensation, we only accept Oklahoma Workers' Compensation.
- 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 a collection agency or attorney for collection and reported to the credit bureau.

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, Dr. Gregory Wilson, holds a minority ownership interest.**

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 ensure 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 free 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.

_____ _____ _____

Date Printed Name Signature

Patient Name: _____ DOB: _____

AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

In order for Invictus Healthcare System to provide you with the best possible care, we may require copies of your medical records. For us to obtain this information, we will need your written permission. Please review the Authorization and Consent for Release of Medical Records below. Your signature on this form will allow us to obtain the necessary information.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

PATIENT SECTION TO COMPLETE		
_____ Today's Date	XXX-XX-_____ Last 4 of SSN	_____ Date of Birth
_____ Printed Patient Name	_____ Patient Signature	

MEDICAL RECORDS USE ONLY DO NOT COMPLETE THIS SECTION	
Record Holder:	Record Holder's Fax Number
Requested Medical Records: ☐ All dictated reports ☐ All radiology reports ☐ All anesthesia reports ☐ All therapy records ☐ Other:_____	

Please Fax Records to 918-994-4090