Dr. Dan T D Nguyen
Neuroradiology & Pain Solutions of Oklahoma
14100 Parkway Commons Drive, Suite 103
Oklahoma City, Oklahoma 73134
PH: 405-286-2060 FAX: 405-242-4007

Legal Name: _____ Date of Birth: _____ Age: _____ Male or Female
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Work: _____
SS#:_____ Email Address: _____
Marital Status: Single, Married, Divorced, Widowed

Race: (please circle one)
American Indian/Alaska Native Black/African American White Hispanic Asian
Native Hawaiian/Pacific Islander Unreported/Refused to Report Other Race
Ethnicity :(please circle one)
Hispanic/Latino Non-Hispanic/Latino Unreported/Refused to Report Race and Identity
Primary Language :(please circle one)
English Spanish Vietnamese Other

PERSON RESPONSIBLE FOR BILL: (If minor, parent or guardian information)
Name: _____ Date of Birth: _____ SS#:_____
Relationship to Patient: _____Address:_____
Home Phone: _____ Cell: _____ Work: _____
Employer: _____ Address: _____

INSURANCE INFORMATION:
Name of insured: _____ Date of Birth: _____ SS#:_____
Relationship to Patient: _____Employer: _____
Name of Insurance Company: _____ Address: _____
Group #: _____ Policy ID#: _____

PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST FOR COPYING

AUTHORIZATION: My signature indicates that I have read above and grant authorization of treatment and I am responsible for payment of fees. I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to physician.

X

Patient or Legal Guardian Signature and Date

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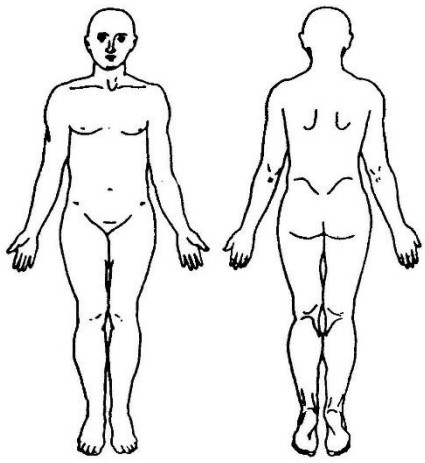
NAME: _____DATE:_____
DOB: _____ AGE: _____ HEIGHT: _____Weight:_____
REFERRING PHYSICIAN: _____PRIMARY CARE PHYSICIAN & PHONE#_____
OTHER TREATING PHYSICIANS, PHONE, AND CONDITIONS-
_____
CHIEF COMPLAINT(S): _____
ON a scale from 0 (no pain) to 10 (excruciating) rate your pain:
At its WORST: _____ At its LEAST: _____ At its USUAL: _____



Describe your pain; Sharp, dull, burning, shooting.

Using the model, indicate the type and location of your pain using the key below

0000 Pins and Needles

XXXX Burning Pain

//// Stabbing Pain

++++ Aching

What makes your pain worse: _____
What makes your pain better: _____
IS THIS INJURY RELATED TO A MOTOR VEHICLE ACCIDENT or WORKER'S COMP INJURY?
YES or NO If YES, Date of Accident: _____
PREVIOUS TREATMENT:
Any Nerve Blocks, Epidural Blocks: Yes No Dates when Rcvd_____
Physical Therapy or other treatment: Yes No Dates when Rcvd_____

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Review of Systems:

Cardiovascular			**Psychiatric**		
Chest pain	0 Yes	0 No	Anxiety	0 Yes	0 No
Difficulty lying flat	0 Yes	0 No	Depressed mood	0 Yes	0 No
Fluid accumulation in the legs	0 Yes	0 No	Difficulty sleeping	0 Yes	0 No
Irregular heartbeat	0 Yes	0 No	Suicidal thoughts	0 Yes	0 No
Palpitations	0 Yes	0 No			
Shortness of breath	0 Yes	0 No			
Gastrointestinal					
Constipation	0 Yes	0 No			
Diarrhea	0 Yes	0 No			
Change in bowel habits	0 Yes	0 No			
Neurologic					
Balance difficulty	0 Yes	0 No			
Difficulty speaking	0 Yes	0 No			
Dizziness	0 Yes	0 No			
Fainting	0 Yes	0 No			
Gait Abnormality	0 Yes	0 No			
Loss of Strength	0 Yes	0 No			
Paralysis	0 Yes	0 No			
Seizures	0 Yes	0 No			
Respiratory					
Shortness of breath	0 Yes	0 No			
Wheezing	0 Yes	0 No			
Peripheral Vascular					
Absent pulses in feet	0 Yes	0 No			
Absent pulses in hands	0 Yes	0 No			
Blanching of skin	0 Yes	0 No			
Cold Extremities	0 Yes	0 No			
Ulcerations of Feet	0 Yes	0 No			
Musculoskeletal					
Joint Stiffness	0 Yes	0 No			
Leg cramps	0 Yes	0 No			
Pain in the shoulder(s)	0 Yes	0 No			
Sciatica	0 Yes	0 No			
Swollen Joints	0 Yes	0 No			
Trauma to ankle(s)	0 Yes	0 No			
Trauma to arms(s)	0 Yes	0 No			
Trauma to hip(s)	0 Yes	0 No			
Trauma to knee(s)	0 Yes	0 No			
Weakness	0 Yes	0 No			

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Please circle if you have previously or are currently experiencing any of the following

Medical history:
Abnormal liver function tests, AIDS/HIV, Alcohol abuse, Anemia, Angina, Anxiety, Arthritis Asthma, Atrial fibrillation, Autoimmune disorder, Bipolar disorder, Bleeding problems,
Cardiac arrhythmia, Chronic Kidney Disease, Cirrhosis, Coronary artery disease, Crohn's disease, Depression, Diabetes type 1/type 2, Drug abuse, Emphysema, Epilepsy, GERD, Gout, Heart attack, Hepatitis B/C, Hypertension, Kidney failure, Pacemaker/ Defibrillator, Schizophrenia, Seizures, Sleep apnea

Surgical history:
Appendix removed, Ankle surgery R/L, Bladder surgery, Bowel surgery, Breast biopsy,
Carpel tunnel release, Cervical fusion, Chiari malformation surgery, Coronary artery bypass graft, Pacemaker/Defibrillator, Gallbladder removed, Gastric bypass/Sleeve, Heart bypass, Hip replacement left/right, Hysterectomy, Knee arthroscopy left/right, Knee replacement left/right, Lumbar fusion, Lumbar laminectomy, Mastectomy, Open reduction internal fixation (ORIF) Partial thyroidectomy, Shoulder arthroscopy left/right, Spine Surgery, Tonsillectomy

Social History:

Do you Smoke/Vape: Yes No Packs per day

Drink Alcohol (Circle One): Occasionally Frequently Daily Never

History of alcohol or drug abuse: Yes No _____

Currently Working: Yes or No Occupation: _____ Employer: _____

Are you disabled? Yes No

Family History:

Anxiety Cancer Chronic pain Depression Diabetes Heart Disease High Blood Pressure Stroke Substance Abuse Other: _____

Allergies: _____

Medication: List ALL medications, strength and quantity:

_____

_____

Are you on Blood Thinners? Yes No

Are you currently undergoing Dialysis? Yes No

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Disclosure of Ownership

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

Dr. Nguyen is obligated to inform you he has NO ownership of Oklahoma Spine Hospital or any of its affiliates.

Dr. Nguyen makes 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 NPS. 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.

_____ _____

Signature of Patient/Print Name Date

Dan T D Nguyen, M.D.
14100 Parkway Commons Drive, Suite 103 OKC, Oklahoma 73134
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FINANCIAL POLICY

In the interest of good business practice, the desire to continue to provide quality health services and to maintain fiscal responsibility, Dan T D Nguyen, M.D.**,** 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.

PAYMENT PLANS: Dr. Dan Thach Dam Nguyen, M.D. has contracted Legacy Medical Management, LLC (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 Dr. Dan Thach Dam Nguyen, M.D.**,** 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 DR. DAN THACH DAM NGUYEN, M.D. FINANCIAL POLICY OUTLINED ABOVE.

_____ _____

Patient Print / Sign **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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Office Policies and Procedures

Office Hours: Our regular office hours are Monday – Friday 8:30 – 4:00. Our phones are from 8:30 – 12:00 and 1:00 – 4:30. 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 405-242-4007. 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.

Paperwork Charges/ Miscellaneous Charges: There will be a $30.00 charge, payable in advance for each form the doctor is requested to fill out (i.e., disability, FMLA, Medical Necessity, etc.). These forms should be turned in at the front desk. Please allow seven business days for processing.

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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 Dan T D Nguyen, 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.

Dan T D Nguyen, 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 Dan T D Nguyen, 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).

Any Other Use or Disclosure of Your PHI Requires Your Written Authorization:

Under any circumstance other than those listed above, Dan T D Nguyen, MD will ask for your written authorization before we use or disclose your PHI. Specifically, Dan T D Nguyen, MD must obtain your written authorization for the use and disclosure of psychotherapy notes, marketing, and the sale of PHI. Dan T D Nguyen 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 Dan T D Nguyen, 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.