NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

NEW PATIENT PAPERWORK

LOCATION: ☐ TULSA ☐ BARTLESVILLE ☐ OKLAHOMA CITY

Referring Doctor: _____

DEMOGRAPHICS:

First Name: _____ Last Name: _____

DOB: _____ Email: _____

In submitting my email, I authorize the Neuropathy Treatment Clinic of Oklahoma to utilize the email address listed above for correspondence of monthly newsletters, weekly appointment reminders, and future marketing material provided by Neuropathy Treatment Clinic of Oklahoma.

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____

ARE YOU A VETERAN? _____ WHAT COLOR? _____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY PHONE: _____ EMAIL: _____

INSURANCE:

PRIMARY: _____ ID: _____

RELATIONSHIP TO POLICYHOLDER: _____ POLICYHOLDER'S DOB: _____

SECONDARY: _____ ID: _____

RELATIONSHIP TO POLICYHOLDER: _____ POLICYHOLDER'S DOB: _____

SOCIAL HISTORY:

DO YOU SMOKE? _____ QUANTITY PER DAY: _____ DRINK ALCOHOL? _____ QUANTITY? _____

MEDICAL QUESTIONS:

DO YOU HAVE A PACEMAKER? _____ DO YOU HAVE A DEFIBRILLATOR? _____

ARE YOU DEPENDENT ON EITHER? _____ ANY OTHER CARDIAC DEVICES? _____

PRIMARY CARE PHYSICIAN? _____ CARDIOLOGIST? _____

NEUROLOGIST? _____ PHARMACY? _____

PHARMACY ADDRESS: _____

IF YOU HAVE HAD ANY SURGERIES, PLEASE LIST THEM HERE:

PROCEDURE	SURGERY YEAR	COMPLICATIONS

FAMILY HISTORY (CHECK ALL THAT APPLY)**:**

	FATHER	MOTHER	BROTHER	SISTER
ARTHRITIS	☐	☐	☐	☐
CANCER	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐
THYROID	☐	☐	☐	☐
NEUROPATHY	☐	☐	☐	☐

ALLERGY HISTORY (PLEASE LIST ALL ALLERGIES)**:**

DIABETIC HISTORY:

ARE YOU A DIABETIC? ☐ YES ☐ NO

WHEN WERE YOU DIAGNOSED?_____ CURRENT HEMOGLOBIN A1C:_____

ARE YOUR BLOOD SUGARS CONTROLLED? ☐ YES ☐ NO FASTING BLOOD SUGARS:_____

DOES YOUR PCP TREAT YOUR DIABETES? ☐ YES ☐ NO IF NOT, WHO DOES?_____

NEUROPATHY HISTORY:

WHAT IS YOUR CHIEF COMPLAINT OF NEUROPATHY? CHECK ALL THAT APPLY.

☐ PAIN ☐ NUMBNESS ☐ TINGLING ☐ PAIN WITH TOUCH ☐ SHOOTING SHOCKS ☐ ACHING

WHERE ARE THESE SYMPTOMS LOCATED?_____

DATE DIAGNOSED WITH NEUROPATHY?_____ DIAGNOSED BY:_____

IF DIAGNOSED BY EMG/NCS, GIVE THE DATE OF THE STUDY:_____

DO I NEED TO TEST FOR PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys become narrowed or clogged. It affects over 8 Million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check if any apply:

- ☐ Foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest
- ☐ Any pain at rest in your lower legs or feet
- ☐ Foot or toe pain that often disturbs your sleep
- ☐ Toes or feet pale, discolored or bluish
- ☐ Skin wounds or ulcers on your feet or toes that are slow to heal
- ☐ Diagnosed with diminished or absent pedal (foot) pulses
- ☐ Suffered a severe injury to the leg(s) or feet
- ☐ Have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)

MEDICATIONS:

MEDICATION NAME	DOSAGE / MG

I, THE UNDERSIGNED, HAVE REVIEWED EVERYTHING ABOVE AND HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ DATE: _____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME:_____ DOB:_____

I AUTHORIZE MY MEDICAL RECORDS TO BE RELEASED FROM MY PROVIDERS/MEDICAL FACILITIES:

DISCLOSE ALL HEALTH RECORDS TO:

NEUROPATHY TREATMENT CLINIC OF OKLAHOMA
ATTN: DR. LIPHARD D'SOUZA
4636 S HARVARD AVE, STE 102
TULSA, OK 74135
918-708-1816
NEUROPATHYOK.COM

MEDICAL INFORMATION TO BE DISCLOSED:

- ☐ COMPLETE MEDICAL RECORD
- ☐ CONSULTATIONS
- ☐ LAB RESULTS
- ☐ CD/FILMS
- ☐ OPERATIVE REPORTS
- ☐ EKG REPORTS
- ☐ ED RECORDS
- ☐ HISTORY & PHYSICAL
- ☐ DISCHARGE SUMMARY
- ☐ X-RAYS
- ☐ OFFICE NOTES
- ☐ PATHOLOGY NOTES
- ☐ NERVE CONDUCTION STUDY/EMG
- ☐ RADIOLOGICAL REPORTS

PATIENT SIGNATURE: _____

PRINT NAME: _____

DATE: _____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

MEDICAL CONSENT FORM

LOCATION: ☐ TULSA ☐ BARTLESVILLE ☐ OKLAHOMA CITY

1. Procedures generally used for treatment are listed below, but not limited to:
   Neuropathy: Office visit, Nerve Conduction Study/EMG, Epidermal Nerve Fiber Density Biopsy, Arterial and VenousUltrasound, U/S Guidance for injection, Nerve Block injections, Acupuncture/trigger point injections, Sanexas/Estim for Neuropathy.

2. The nature and purpose of the procedure(s) and inherent risks, benefits, and alternative options have been discussed with me by Dr. D'souza's, or his designee. I have had the opportunity to have any questions answered about my condition or the below named patient's condition), the proposed procedures for treatment and alternative procedures or treatments. I acknowledge that although rare, serious complications may arise as a result of treatment. These include but may not be limited to: bleeding, bruising, infection, injury to adjacent structures or organs, drug or allergic reactions, or even death.

3. I consent to the performance of procedures in addition to or different from those planned, whether or not arising from presently unforeseen conditions, which in the above named provider, associates, or designee may consider necessary or advisable in the course of the operation. I also consent to any treatment in which any named physician or their designee consider necessary or advisable in connection with treatment, such as any complication that may develop from such procedure.

4. I consent to the administration of such anesthetics as may be considered necessary or advisable by the medical provider responsible for this service. I acknowledge that, although rare, there are risks associated with anesthesia including, but not limited to: infection, bleeding, nerve damage, paralysis, or even death.

5. I consent to the photographing or televising of procedures to be formed, including appropriate portions of the anatomy for medical, scientific, or educational purposes provided identity is not revealed by the pictures or by the descriptive texts accompanying them.

6. For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.

7. I consent to the disposal by Medical Center Authorities of any tissue or body parts, which may be removed.

8. If I have an order for"no CPR" (no cardiopulmonary resuscitation) or DNR (do not resuscitate), I understand that this order will be suspended and hereby consent to the suspenstion of the "no CPR" or DNR order from the time that I enter the facility performing the procedure until I leave the facility.

PROVIDER SIGNATURE:_____ WITNESS SIGNATURE:_____

PATIENT SIGNATURE:_____ DATE:_____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

HIPAA PRIVACY POLICIES AND PROCEDURES

GENERAL RULE: NO USE OR DISCLOSURE
The office of the Neuropathy Treatment Clinic of Oklahoma must not use of disclose protected health information (PHI), except as these Privacy Policies and Procedures permit or require.

ACKNOWLEDGMENT AND OPTIONAL CONSENT
The office of the Neuropathy Treatment Clinic of Oklahoma will make a good faith effort to obtain a written acknowledgment of receipt of our Notice of Privacy Practices from a patient before we use or disclose his or her protected health information (PHI) for treatment, to obtain payment for that treatment, or for our healthcare operation (TPO).

Our office's use or disclosure of PHI for our payment activities and healthcare operations may be subject to the minimum necessary requirements.

Our office will stay familiar with Oklahoma's privacy law. If required by state law, or as directed by the Neuropathy Treatment Clinic of Oklahoma, we will also seek consent from a patient before we use or disclose PHI for TPO purposes –in addition to obtain an Acknowledgment of receipt of our Notice of Privacy Practices.

a. Obtaining consent – If consent is to be obtained, upon the individual's first visit as a patient (or next visit is already a patient), our office will request and obtain the patient's written consent for use and disclosure of the patient's PHI for treatment, payment and healthcare operations. Any consent we obtain must be on our consent form, which we may not alter in any way. Our office will include the signed consent form in the patient's chart.
b. Exceptions – Our office does not have to obtain the patient's consent in emergency treatment situations; when treatment is required by law; or when communications barriers prevent consent.
c. Consent Revocation – A patient from whom we obtain consent may revoke it at any time by written notice. Our office includes the revocation in the patient's chart. There is a space at the bottom of our consent form where the patient can revoke the consent.
d. Applicability – Consent for use or disclosure of PHI should not be confused with informed consent for treatment. The section applies to our practice.

AUTHORIZATION
In some cases, we must have proper, written authorization from the patient or patient's personal representative before we use or disclose a patient's protected health information for any purpose, except payment, or as required or permitted without consent or authorization. The office of the Neuropathy Treatment Clinic of Oklahoma will use the authorization form and will act in strict accordance with the authorization.

a. A patient may revoke an authorization at any time by written notice.
b. The office of the Neuropathy Treatment Clinic of Oklahoma will use or disclose protected health information as permitted by a valid authorization we receive from another healthcare provider.

ORAL AGREEMENT
Our office may use or disclose a patient's protected health information with the patient's oral agreement. We may use professional judgment with common practice for the patient's best interest in allowing a person to act on behalf of the patient's best interest in allowing a person to act on behalf of the patient to pick up supplies, x–rays, etc. We will do all possible to verify the identity of the person that this information is released to. Our office does not do marketing that would involve the release of any information about a patient. An exception to the oral or written agreement would be for coroners, medical examiners, and funeral directors, reporting of neglect or abuse to law enforcement if required by law, etc.

MINIMUM NECESSARY
Our office will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary protected health information to accomplish the intended purpose.

NOTICE OF PRIVACY PRACTICES

The Neuropathy Treatment Clinic of Oklahoma will maintain a Notice of Privacy Practices as required by Privacy Rules. We will use and disclose protected health information in conformance with the contents of Notice of Privacy Practices and will revise them whenever there is a material change to our legal duties, the patient's rights, etc. The Neuropathy Treatment Clinic of Oklahoma will provide a Notice of Privacy Practices to any person who requests it. This notice will be posted and will be available for patients to take with them. The Neuropathy Treatment Clinic of Oklahoma will make a good faith effort to obtain from the patient a written Acknowledgment of Receipt of our Notice of Privacy Practices.

PATIENT'S RIGHTS

Our office will honor the rights of the patient regarding their protected health information. With rare exceptions, we will permit the patients to request access to the protected health information we hold. We may offer to provide a summary of the information in the chart. Patients have a right to amend their protected health information and other records for as long as we maintain them. We may deny a request to amend protected health information or record If we did not create the information, if we believe the information is accurate and complete, or we do not have the information. We will not physically alter or delete existing notes in a patient's chart. We will inform the patient when we agree to make an amendment. Patients have a right to an accounting of certain disclosures our office made of the protected health information within the 6 years prior to their request. If information is used or released other than for payment, a record will be kept in the chart. We are not required to account for disclosures we made (a) before October 16, 2016; (b) to the patient, (c) to or for notification of persons involved in a patient's healthcare or payment for healthcare (d) for treatment or payment (e) national security or intelligence purposes (f) to correctional facilities or law enforcement officials regarding inmates, or (g) according to an Authorization signed by the patient or the patient's representative. Our patients have the right to request our office to restrict use or disclosure of their protected health information, including for treatment, payment, or healthcare operations. We have no obligation to agree to the request but if we do, we will comply with our agreement. We may terminate an agreement restricting use of disclosure of protected health information by a written notice of termination to the patient. We will document in the patient's chart any such agreed to restrictions. Our office will be aware of and respect the patient's rights regarding their protected health information.

STAFF TRAINING AND MANAGEMENT

The Neuropathy Treatment Clinic of Oklahoma will train all members of our office in these Privacy Policies and Procedures, as necessary and appropriate form them to carry out their functions. We will complete the privacy training of our existing workforce by October 17, 2016; and we will train each new staff member within a reasonable time after they begin their job. Our office will develop, document, disseminate, and implement appropriate discipline policies for staff members who violate our Privacy Policies and Procedures, the Privacy Rules, or other applicable federal or state privacy law.

COMPLAINTS

The Neuropathy Treatment Clinic of Oklahoma will implement procedures for patients to complain about our compliance with our Privacy Policies and Procedures and Privacy Rules. We will also implement procedures to investigate and resolve such complaints. Only the Neuropathy Treatment Clinic of Oklahoma may change these Privacy and Policy Procedures.

HHS ENFORCEMENT

The Neuropathy Treatment Clinic of Oklahoma will give the U.S. Department of Health and Human Services (HHS) access to our facilities, book, records, accounts, and other information sources. We will cooperate with any compliance review or complaint investigation by HHS, while preserving the rights of our practice.

I have received and acknowledge that I have read a copy of Neuropathy Treatment Clinic of Oklahomas Notice of PRIVACY PRACTICES.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____ DATE: _____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

STATEMENT OF FINANCIAL RESPONSIBILITY

Neuropathy Treatment Clinic of Oklahoma appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know their coverage and benefits. The patient authorizes NTCO to furnish information to insurance carriers concerning their care. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, of if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at NTCO.

If any tests are performed by the lab you may receive a separate bill from their offices that you are financially responsible for. Full payment for NTCO services provided is due at the time of services rendered; fees and interest may be charged.

If payment is denied for lack of authorization, the patient is responsible for payment in full.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Some health insurance carriers require the patient to pay a co-pay for services rendered. This is a contract between you and your insurance carrier. Payment of all co-pays is expected at the time the service is rendered for the patient.

Initial:_____ I understand that I am responsible for co-payment and deductible/co-insurance as dictated by my insurance carrier.

Initial:_____ I have read the above policy regarding my financial responsibility to the Neuropathy Treatment Clinic of Oklahoma, for providing medical services to me or the above named patient. I certify that the information is true and accurate to the best of my knowledge. I authorize my insurer to pay any benefits directly to the Neuropathy Treatment Clinic of Oklahoma. I understand that my co-payment, deductible/co-insurance that has been dictated by my insurance carrier and any amount remaining after such payment has been paid by my insurer carrier becomes the patient's responsibility.

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or other obligations to work or family. However, we ask that you you call the office 24 hours prior to your appointment time to cancel or reschedule your appointment.

I understand that:

Initial:_____ If I miss an appointment without canceling in advance, I will be charged a $50 no-show fee.

Initial:_____ After **FIVE** cancelled appointments or **THREE** missed appointments with **NO CONTACT** to the clinic to reschedule my appointment, I will be **DISMISSED** from my treatment program.

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

MEDICAL HISTORY: (Please circle all that apply)

CARDIOVASCULAR
- Aneurysm
- Angina
- Deep Vein Thrombosis (DVT)
- Dysrhythmia
- Hypertension (HTN)
- Murmur
- Hear Attack (MI)
- Other Heart Disease

EARS
- Hearing Aids

NOSE/SINUSES
- Allergic Rhinitis
- Sinus Infection

MOUTH/THROAT/TEETH
- Dentures

RESPIRATORY
- Asthma
- Bronchitis
- COPD
- Bronchitis/Emphysema
- Pleuritis
- Pneumonia

EYES
- Blindness
- Cataracts
- Glaucoma
- Wear
- Glasses/Contacts

HEAD
- Trauma

GASTROINTESTINAL
- Cirrhosis
- GERD
- Gallbladder Disease
- Heartburn
- Hemorrhoids
- Hepatitis
- Hiatal Hernia
- Jaundice
- Ulcer

GENITOURINARY
- Hernia
- Incontinence
- Nephrolithiasis
- Other Kidney Disease
- STDs
- UTI(s)

MUSCULOSKELETAL
- Arthritis
- Gout
- M/S Injury

ENDOCRINE
- Goiter
- Hyperlipidemia
- Hypothyroidism
- Thyroid Disease
- Thyroiditis
- Type I DM
- Type II DM

NEUROLOGICAL
- Epilepsy
- Seizures
- Severe Headaches (Migraines)
- Stroke
- Transient Ischemic Attack (TIA)

PSYCHIATRIC
- Bipolar Disorder
- Depression
- Hallucinations (Delusions)
- Suicidal Ideation
- Suicide Attempts

SKIN
- Dermatitis
- Mole(s)
- Other Skin Condition(s)
- Psoriasis

INFECTIOUS
- HIV
- STDs
- Tuberculosis (DZ)
- Tuberculosis (Exposure)

HEME/ONC
- Anemia
- Cancer

OTHER CONTITIONS

_____

_____