Last Name:_____ First Name:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: _____ Cell:_____

DOB:_____ SS#:_____
Email:_____

Occupation:_____
Employer:_____

Ethnicity:_____

Primary Insurance:_____

Policy #:_____ Group #:_____

Policy Holder's Name:_____
DOB:_____

Secondary Insurance:_____

Policy #:_____ Group #:_____

Policy Holder's Name:_____
DOB:_____

How did you Hear about us:_____

Primary Care Doctor:_____
Phone:_____

Pharmacy:_____
Phone:_____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

MEDICAL HISTORY

Name:_____ Date:_____

CIRCLE ALL THAT APPLY:

Diabetes	Fibromyalgia	Tumors	Epilepsy	Neuropathy
Heart Problems	Arthritis	Gout	Asthma	Glaucoma
Gastric Ulcers	Skin Disorder	Anemia	Bursitis	AIDS(HIV)
Tuberculosis	Lung Disease	Stroke	Hepatitis	Sickle Cell
Osteoporosis	Bleeding Problems	Colitis	Cancer	High Cholesterol
Poor Circulation	Blood Pressure	Thyroid	Kidney	Mental Disorder
Rheumatic	GERD	STD		Implants

Other_____

Do you Smoke? YES NO If YES How many per day:_____

Do you drink Alcohol? YES NO If YES How many per day:_____

Are you Pregnant? YES NO If YES how far along:_____

Do you have a Pacemaker? YES NO Do you have a Defibrillator? YES NO

AGE:_____ Height:_____ Weight:_____

Allergies:

_____

_____

_____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

Name:_____ Date:_____

SURGICAL HISTORY

Provide history for past 7 years

Procedure	**Date of Surgery**	**Complications**
_____	_____	
_____	_____	
_____	_____	
_____	_____	

FAMILY HISTORY

(Check all that apply)

	Father	Mother	Brother	Sister
Diabetes	☐		☐	☐
Heart Disease	☐	☐	☐	☐

High Blood Pressure ☐ ☐ ☐ ☐

Arthritis ☐ ☐ ☐ ☐

Thyroid ☐ ☐ ☐ ☐

Cancer ☐ ☐ ☐ ☐

EMERGENCY CONTACT

Contact Name:_____ Relationship:_____

Phone:_____ Patient Signature:_____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

Name:_____ Date:_____

MEDICATIONS

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name:_____ Date:_____

Constitutional: Fever Chills Headache Fatigue Weight Loss/ Gain

Eye, Ears, Nose, Mouth, Throat: Blurred Vision Strain/Pain Double Vision Ear Pain Difficulty Swallowing Difficult with Smell

Heart: Chest Pain Palpitations Difficulty breathing when flat Swelling/Edema Fainting

Lungs: Shortness of Breath Cough Sputum Production Wheezing/Asthma Coughing up Blood

Gastrointestinal: Abdominal Pain Indigestion Nausea Vomiting Change in Bowel habit Blood in Stool Loss of Bowel Control

Urinary System/Gynecological: Pain during Urination Blood in Urine Urinary Frequency Urinary Urgency Vaginal/Penile discharge

Neurological: Focal Neurological Deficit Weakness Numbness/Tingling Incoordination Seizure Stroke Tremors

Musculoskeletal: Joint Pain/Spasms Joint Swelling Joint Stiffness Weakness

Integumentary: Rashes Loss of Hair Itching

Psychosocial: Depression Anxiety Insomnia Recent Stressors Recent Lifestyle Change

Endocrine: Excessive Thirst Excessive Swelling

Blood and Lymphatic Systems: Bleeding Problems Swollen Glands

Allergic/Immunologic: Allergy Symptoms Allergic Reactions

Do I Need a 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.

Name:_____ Date:_____

Circle YES or NO:
Test for PAD

1. Do you have foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest? YES NO
2. Do you experience any pain at rest in your lower legs or feet? YES NO
3. Do you experience foot or toe pain that often disturbs your sleep? YES NO
4. Are your toes or feet pale, discolored or bluish? YES NO
5. Do you have skin wounds or ulcers on your feet or toes that are slow to heal? YES NO
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses? YES NO
7. Have you suffered a severe injury to the leg(s) or feet? YES NO

8. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? YES NO ☐

Patient Signature:_____

Physician Signature:_____ Date:_____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

Patient Name:_____ **Date:**_____

Primary Care Physician: (please give name of doctor)

_____

Neuropathy History

Chief Complaint: (circle all that apply)

Pain Numbness Tingling Pain with touch Shooting shocks Burning Aching

Where on your body do you experience these symptoms?

_____

_____

How long have you suffered with these symptoms?

_____

When were you diagnosed with peripheral neuropathy?

_____

How was the diagnosis made?

Neurologist? (please give name of doctor)_____

EMG/NCS?_____ Date of study:_____

Are you a Diabetic? YES NO If so, when were you diagnosed?_____

Current hemoglobin A1C _____

Are you blood sugars controlled? YES NO What are your fasting blood sugars? _____

Who treats your diabetes? (please give name of doctor) _____

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

1810 East 15th St
Tulsa, OK 74104
918.901-9550

Patient Name _____ Date of Birth _____ Initial Date of Treatment _____

Consent for Medical Procedure

1. **Procedures general used for treatment are listed below, (but not limited to):**

   Neuropathy
   Office Visit
   Nerve Conduction Study/EMG
   Epidermal Nerve Fiber Density Biospy
   Arterial and Venous Ultrasound
   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 above 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 or brain damage, paralysis, or even death.
5. I consent to the photographing or televising of procedures to be performed, 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 suspension of the "no CPR" or DNR order from the time that I enter the facility performing the procedure until I leave the facility.

I authorize the performance for the above listed procedure(s) that are relative to my treatment to be performed by

Dr. Liphard D'Souza MD /Jenny Harmon PA-C____ Date: _____
Provider's Printed Name

_____ _____ _____
Provider's Signature Patient's Signature Witness' Signature

NEUROPATHY
TREATMENT CLINIC OF OKLAHOMA

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Last 4 digits of SSN: _ Date of Birth: _____ _____

Address: _____ City:_____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____ Email: _____ _____

I AUTHORIZE REPRESENTATIVES FROM THE FOLLOWING FACILITY/FACILITIES

Attn:_____

TO DISCLOSE ALL HEALTH INFORMATION AND REPORTS TO:

Neuropathy Treatment Clinic of Oklahoma

Dr. Liphard D'Souza MD and/or Jenny Harmon PA-C

1810 East 15th St, Tulsa OK 74104

P 918.901.9550

www.neuropathyok.com

Description of Health Information to Be Disclosed:

( ) Complete Medical Record
( ) History & Physical
( ) Consultations
( ) Discharge Summary
( ) Lab Results
( ) X-Rays
( ) CD/Films
( ) Office Notes
( ) Operative Reports
( ) Pathology Reports
( ) EKG Reports
( ) Nerve Conduction Study/EMG
( ) ED Record
( ) Radiological Reports

Patient Name Print: _____Patient Signature: _____

Date: _____

HIPPA

PRIVACY POLICIES & PROCEDURES

GENERAL RULE: NO USE OR DISCLOSURE

The office of the Neuropathy Treatment Clinic of Oklahoma must not use or disclose protected health information (PHI), except as these Privacy Policies and Procedures permit or require.

ACKNOWLEDGEMENT AND OPTIONAL CONSENT

The office of the Neuropathy Treatment Clinic of Oklahoma will make a good faith effort to obtain a written acknowledgement 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 judgement 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 Acknowledgement of Receipt of our Notice of Privacy Practices.

PATIENTS 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.

Acknowledgement of Receipt of

Notice of Privacy Practices

I may refuse to sign this acknowledgement.

I, _____ Acknowledge that I have received a copy of Neuropathy Treatment Clinic of Oklahoma Notice of privacy practices.

Patient Signature:_____

Date:_____

Witness:_____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prohibited obtaining the acknowledgment
- ☐ Other:_____