STEPHANIE TAYLOR, M.D. **JESSICA ENIX, M.D.**

PHONE: (405) 265-2210
FAX: (405) 696-9092

Dear Patient,

On behalf of our entire team, welcome to Surgical Partners of Oklahoma. We are honored that you and your referring physician have chosen us for your surgical care. Our goal is to provide you with the highest quality medical treatment in a supportive and professional environment, and we understand that undergoing surgery can be a significant event. We are committed to making your experience as comfortable and clear as possible by providing thorough information at every step of your journey.

Your First Visit

During your initial consultation, your surgeon will review your medical history, discuss your diagnosis, and go over all available treatment options. We encourage you to bring a list of questions and a trusted friend or family member to help take notes.

Practice Information & Policies

To help our office run smoothly, please keep the following in mind:

- **Arrival:** Please arrive [15] minutes before your scheduled appointment to complete any necessary paperwork.
- **Insurance: Although we make every effort to ensure we have the correct referrals, approvals and pre-authorizations for each patient, it is imperative, you, as the subscriber, be familiar with your specific insurance plan. Medical fees not covered by insurance are the responsibility of the patient and will be billed accordingly.**
- **What to Bring:** Please bring your photo ID, current insurance card, and a list of all medications you are currently taking.
- **Cancellations:** If you need to reschedule, we kindly ask for [24/48] hours' notice so we can offer that time to another patient.

Our Commitment to You

Communication is a vital part of your recovery. If you have any questions regarding your upcoming procedure, or post-operative care, please do not hesitate to call our office at 405-265-2210

Thank you for trusting us with your health. We look forward to meeting you soon.

Sincerely,

Surgical Partners of Oklahoma

SURGICAL PARTNERS OF OKLAHOMA

Name _____ Date: _____ Age _____ Weight: _____ Height: _____

Accompanied by: _____ Relationship to patient: _____

PERSONAL HISTORY: PLEASE NOTE ALL CURRENT OR PAST MEDICAL CONDITIONS

Y N Heart Trouble
Y N Irregular heartbeat
Y N High blood pressure
Y N Stroke
Y N Rheumatic Fever
Y N Lung disease
Y N Asthma
Y N Pneumonia
Y N Blood vessel disease(Phlebitis)
Y N Jaundice
Y N Pancreatitis
Y N Ulcers
Y N Back trouble
Y N Muscle weakness
Y N Paralysis
Y N Epilepsy or seizures
Y N Arthritis
Y N Glaucoma
Y N Blood disease (anemia)
Y N Blood Transfusion
Y N Sickle cell trait or disease
Y N Kidney disease
Y N Dialysis _____days
Where_____
Y N Urinary problems
Date treated_____
Y N Diabetes
Y N Cancer
Y N Other Medical Issue_____
_____
Y N Abnormal chest X-ray
Y N Abnormal EKG
Y N Abnormal bleeding tendencies
Y N Anticoagulant therapy
Y N NSAIDS
Y N Blood thinners or aspirin
Y N Positive HIV/AIDS blood test

Y N Reaction to tape, bandaids gloves, balloons, latex
Y N Fracture of facial bones
Y N Fracture of neck or back
Y N Motion sickness
Y N Pacemaker
Y N Implanted defibrillator
Y N Joint replacement
Y N Heart valve replacement
Y N Pregnant currently
Y N Bronchitis
Y N Emphysema
Y N Tuberculosis
Y N Hepatitis
Y N Cirrhosis
Y N Gallbladder problems
Y N Any abnormal reactions to anesthesia or sedation medication

Do you have:

Y N False or loose teeth
Y N Dental Bridges
Y N Glasses or contacts
Y N Body piercing
Y N Hearing aid

Do You:

Y N Smoke _____pack(s) per day
Y N Former Smoker_____
Y N Drink alcohol
Y N Use recreational (street) drugs
List_____
_____
_____

List allergies (drug, food)

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List medications & dosages

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List prior surgeries & dates

1._____
2._____
3._____
4._____
5._____
6._____
7._____

List all Doctors you are currently seeing

Primary Care_____
Cardiologist_____
Pulmonologist_____
Pain Mgmt_____
Oncologist_____
Other_____

Patient signature _____

PATIENT INFORMATION

Date _____ Pharmacy Name _____

Pharmacy Location _____

Patient Name _____

First Middle Last

Mailing Address _____

City _____ State _____ Zip _____ Email _____

Preferred Phone: _____ Other Phone _____

Birthdate _____ SSN _____ Single Married Widowed Divorced

Age _____ Sex _____ Race _____ Primary Language _____

Employed by _____ Work Phone _____

Referred by _____

Do you have an Advanced Directive (Yes/No) _____ If yes, on file with _____

Spouse _____ if under 18, Parent _____

EMERGENCY CONTACT (OUTSIDE THE HOME)

Name _____ Relationship to patient _____

Phone number _____

Please complete below if insured and/or responsible party is DIFFERENT than patient

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)

Name _____ Relationship to patient _____

Birthdate _____ SSN _____ Phone _____

Mailing Address _____

City _____ State _____ Zip _____

MEDICAL INSURANCE INFORMATION (IF NO CARD OR PATIENT IS NOT SUBSCRIBER)

Medical Insurance Carrier _____

ID # _____ Group # _____ Employer _____

Name of insured (if different than patient) _____

Patient relationship to insured _____ Insured Sex _____

Insured birthdate _____ Insured SSN _____

RELEASE OF INFORMATION

(We cannot file insurance without a copy of your insurance card(s) for verification of coverage.)

I hereby authorize my physician to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A copy of this authorization shall be considered as valid as the original document. I hereby authorize payment directly to my physician for this illness or injury, for the physician's benefits otherwise payable to me, but not to exceed my indebtedness to said physician. I agree to pay the physician for all my charges whether or not covered by the assignment. The responsible party hereby agrees that the physician office or the party responsible for the billing of these services may check credit with a source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information about a medical condition that is considered a communicable venereal disease, including, but not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state all the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I have been notified that I may receive services from the Nurse Practitioner or Medical Assistance at this office.

Patient or Authorized Person Signature _____ Date _____

HIPAA CONSENT

I, _____ (patient or authorized person), give permission to Surgical Partners of Oklahoma and/or staff to leave information pertaining to my health including, but not limited to, dates and times of appointments, lab/x-ray results and other information as they feel necessary, on my answering machine and/or e-mail. I understand this could result in unintentional disclosure of my personal health information

Patient or Authorized Person Signature _____ Date _____

If you have any objections to the above, please list _____

I also give permission to Surgical Partners of Oklahoma and/or staff to discuss my health conditions with the following people: (examples: spouse, parent, children, sibling)

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices posted in our facility describes how Surgical Partners of Oklahoma may use and disclose your medical information and how you can get access to this information. Please review it carefully.

A complete copy of the Facility's Notice of Privacy Practices is posted in the office. By signing below, you acknowledge the Facility's Notice of Privacy Practices has been made available to you and a copy will be provided to you at your request.

Patient or Authorized Person Signature _____ Date _____

If authorized person, relationship to patient _____

SURGERY OPIOID CONSENT FORM

Patient Name:	Date of Birth:
The doctor may prescribe Opioids to control and manage post-surgical pain.	
Alternative options to opioids are Over the counter pain medications such as Tylenol, Advil, Excedrin.	

Instructions: ***Please review the information listed below and put your initials next to each item when you feel you understand and accept what each statement says.***

	Initials
My surgeon will prescribe an opioid medication to help me control and manage post-surgical pain.	
This medicine is used to decrease and manage my pain but will not take away my pain completely.	
I will stop using the opioid medicine as soon as my pain is manageable and will use over the counter pain relievers if possible to manage the pain.	
I will contact my provider if the medicine does not control my pain when I take it as prescribed or if I have any adverse reactions to it.	
I will follow-up with my provider for post-surgical consultations as instructed or requested by my provider.	
If I do not use all of the medicine prescribed, I will ensure that it is disposed of properly in order to prevent its misuse by someone else.	
I will safely store the medicine to minimize the risk that children or other people will take it.	
When I take this medicine it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.	
When I take this medication, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.	
I may become physically or psychologically dependent or addicted to this medicine if I take them continuously so I agree to stop using them at the earliest possible time and to take no more than is necessary to control my pain.	
I have told my provider if I or anyone in my family has had any problems with mental illness or with controlling drug or alcohol use in the past.	
Taking too much of my pain medication, or mixing my pain medications with drugs, alcohol, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.	
It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.	
I will not use any illegal substance, such as cocaine, etc., while taking this medicine.	
If I travel out of the country while taking this medicine, I will notify the appropriate travel authority (usually the consulate website of the country) and obtain a note from my provider before travel, as traveling out of country with opioids may pose problems.	
For females: I understand it is my responsibility to inform my provider if I am pregnant.	

Signature of patient or guardian	Date
Printed name of patient or guardian:	

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Stephanie Taylor and Dr. Brady Hagood have an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Dated:_____

HPI COMMUNITY HOSPITAL

Pre-Admission Testing Decision Tool

HPI NORTHWEST SURGICAL HOSPITAL

Today's Date: Date of Surgery:

Name:_____ DOB:_____ Ht:_____ Wt:_____ Surgeon:_____

Medical History (Section 1)		
Kidney disease or dialysis	Yes	No
Liver disease	Yes	No
Diabetic/Pre-Diabetic/insulin resistant	Yes	No
Anemia/HIV/bleeding disorder	Yes	No
Lung disease (uncontrolled asthma/COPD/ Emphysema) or symptoms of lung disease	Yes	No
History of heart disease, Coronary Artery Disease, Congestive Heart Failure, stent placement, heart attack, abnormal stress test, or abnormal EKG	Yes	No
History of TIA or stroke (within last 12 months)	Yes	No
History of blood clots (within last 12 months)	Yes	No
History of cancer that required radiation or chemotherapy (within last 12 months)	Yes	No
Current alcohol or drug ABUSE	Yes	No
Pacemaker or Automatic Implantable Cardioverter Defibrillator (AICD)	Yes	No
History of Seizures	Yes	No

Medications (Section 2)		
NSAIDS	Yes	No
Anticonvulsants	Yes	No
Diet pills (i.e. Phentermine, Adipex, Qsymia)	Yes	No
GLP-1 (Semaglutide, Ozempic, Mounjaro, etc.)	Yes	No
SGLT-2 (Jardiance, Farxiga, Synjardy, etc.)	Yes	No
Diabetes (Metformin, Glimepiride, Januvia, etc.)	Yes	No
Blood Pressure	Yes	No
Diuretics (water pill)	Yes	No
Nitrates or other heart medication	Yes	No
Digoxin	Yes	No
Anticoagulants (blood thinners)	Yes	No

Metabolic Activity (Section 3)- Are you able do the following without stopping to rest? Circle the highest number you are able to achieve.		
1. Feed, dress yourself	Yes	No
2. Walk indoors around the house	Yes	No
3. Walk 2 blocks on level ground	Yes	No
4. Climb a flight of stairs without stopping or walk up a hill	Yes	No
5. Run a short distance	Yes	No
6. Do moderate extended work around the house such as vacuuming, sweeping, and dusting	Yes	No
7. Do heavy work around the house such as scrubbing floors, or moving heavy furniture	Yes	No
8. Do yard work such as raking leaves, weed-eating, or pushing a high power mower	Yes	No
9. Participate in moderate recreational activities such as doubles tennis, dancing, bowling, walking golf course	Yes	No
10. Participate in strenuous sports such as swimming, singles tennis, football, basketball, or skiing	Yes	No
If you answered "No" to any of the above questions in section 3, is the limitation due to pain in the extremities?	Yes	No
Does any activity listed in section 3 cause shortness of breath, chest tightness, or chest pain?	Yes	No

*Internal office use: If yes to this question, patient will need Pre-Admission Testing

Addition Information:

Outsourced labs: Where _____ When _____

SPO
SURGICAL PARTNERS OF OKLAHOMA PLLC

Patient Name: _____ **Date of Birth:** _____ **Patient identifier:** _____

Patient-Provider Agreement for Ongoing Use of Opiate (Narcotic) Medication

Purpose of Agreement: We used to believe that using opioids for long-term pain was safe. We now know that opioids can be harmful. Using opioid medicine is risky, and can cause overdose and addiction. There is also the risk of becoming addicted or having a relapse if you have a history of prior addiction. The extent of this risk is not certain. Because these drugs are likely to be abused, there are strict rules set by the State of Michigan law.

Our office will review this agreement with you so that you get the best pain relief and you know how to lower the chances of possible harm to yourself and others while you are taking this medication. This agreement also lays out the rules for getting opioids including the role of our clinic and your provider.

- The use of the following medicine(s): _____
- Is only one part of my treatment for: acute postop pain (no more than 6 weeks after surgery)
- The Primary Prescribing Doctor is: Jessica L Enix MD FACS

Terms you should know:

- Psychological dependence – It is possible that stopping the drug will cause you to miss or crave it.
- Tolerance – You may need more and more drug to get the same effect.
- Addiction – You may become dependent on a drug and unable to stop using it without suffering unsafe effects.
- Overdose – Taking more than the amount of medication prescribed to you or using with alcohol or other drugs can cause you to stop breathing, causing a coma, brain damage, or even death.

The goals of this medicine are:

Acute postop pain control, if I require continued narcotic prescriptions beyond 6 weeks after surgery, then I ***WILL*** seek care with chronic pain management from another licensed medical provider.
Opioid medications will not get rid of my pain fully. The goal for treating my pain is to improve my day-to-day function.

My provider will work with me to find other options to opioid medicines to control my pain and improve my day to day function.

What should I know about this medication?

Opioid medications often have side effects, which may include, but are not limited to:

- Itching or rash
- Severe constipation; trouble urinating or passing stool
- Depression getting worse
- Problems thinking clearly or sleepiness

Using pain-relieving medications with alcohol, illegal or illicit drugs, or benzodiazepines can cause:

- Overdose
- Trouble breathing
- Death

Other risks:

- Opioids can cause sleepiness, decreased response time, affect decision-making, and increase tolerance. Thus, it can be unsafe for me to operate heavy gear or drive while taking opioids.
- **Pregnancy:** If I am pregnant or thinking about becoming pregnant, I should discuss taking an opioid medication with my provider prior to taking any medications.
- **Physical dependence:** Stopping the use of a drug quickly may cause withdrawal symptoms, which could include: runny nose, stomach cramping, rapid heart rate, loose stool, sweating, anxiety, bad temper, problems sleeping, or goose bump

Ways to lower harm from this medication:

To lower my chances for harm from my opioid medication I agree that:

- I will take my opioid medication as prescribed. I will not take more than my prescribed amount without being told by my provider. This means I will not run out of my medication early.
- I agree to take only the opioid medication prescribed to me, even if another person offers me the same opioid medication, or another opioid medication that I have used in the past.
- I will not take street drugs or illegal drugs, those not prescribed to me, or abuse alcohol.
- I will not operate motor-powered tools or gear after starting an opioid medication or after a change (such as a dose increase) until I know how the medicine affects me. I will not drive or operate motor-powered equipment if I ever feel drowsy, dizzy, or not quite myself.
- Theft or illegal use of opioid medications is common. They can even be stolen out of my home by visitors or curious young people. Therefore, I will hide or secure my opioid medications. I will consider using a lock box or another way to lock up my opioid medications.
- I will get rid of any unused opioid medications in a safe way, such as at a drop box at certain pharmacies or police departments. If you have any questions on safe drop box location's we can provide you further assistance
- I know the clinic must notify the police if it believes there is illegal action relating to my opioid medication, such as selling or giving away my opioid medication to other people.

If I take this medicine and drink alcohol, take some medications related to anxiety treatment, or use illegal drugs or use drugs prescribed by other providers:

- I may not be able to think clearly
- I could risk hurting myself (such as a car crash)
- I could become ill or even die

I am in charge of my medicine.

- I know my medicine will not be replaced if it is lost. If my medication has been stolen and I complete a police report about the theft, an exception may be made.
- I will not share my opioid medications with anyone or sell them to anyone. This violates federal law and will cause my provider to stop prescribing opioids to me.

I agree to the following:

I will keep all appointments set up by my doctor

- I will be on time for appointments. If I arrive late to an appointment for prescription refills, my appointment may be rescheduled.
- If I miss my appointments, it may not be safe for me to stay on this medicine.

I will only use one pharmacy to fill these prescriptions. This is on file in my chart, no changes to this pharmacy will be made unless completed in person.

When asked, I will give a urine and/or blood sample to help monitor my treatment.

- My doctor will check my prescription fill history by Oklahoma Patient Prescription Monitoring Program (OK PMP) as required by State of Oklahoma Law and may call my pharmacy.
- If my doctor decides that the risks outweigh the benefits of this medicine, my medicine will be stopped in a safe manner.

I can only get this prescription for the listed controlled substance from **Dr Enix**

- I will not get controlled medications from other providers (including dentists, the Emergency Room, specialists or other providers), without checking with my prescribing doctor.
- Refills will be given only during normal office hours. Clinic policy prevents on-call doctors from giving controlled-substance prescriptions.

What are reasons for ending the agreement?

I may not be able to obtain controlled prescriptions from this clinic if I take more medication than is prescribed, if I fail to give requested urine or blood for testing, if those tests fail to contain the proper amounts of my prescribed medication, if non-prescribed medications (from friends, other prescribers, the ED, street purchases) are present, or if illegal drugs are present.

I may not be able to be seen in this clinic if I am disruptive or threaten clinic staff. I understand that under State of Oklahoma law, the non-medical use of controlled substances (lying to get medications, giving or selling these medicines to others) is a crime and will result in the end of my controlled substance treatment.

By signing below, I agree that I have read and understood the information above. Any questions I have about this agreement have been answered. If I am not able to keep the promises made in this agreement, I will inform you. I understand that if I do not follow this agreement, my provider can choose to stop giving me my opioid medication treatment. If this occurs, I understand that the clinic will let me know this in person or will contact me at my last known address or phone number.

Patient Signature: _____
Printed Name: _____
Date: _____

Provider Signature: _____
Printed Name: _____
Date: _____