Oklahoma Pain
TREATMENT CENTERS
Blake Christensen, D.O.
BDC Medical, PLLC

p. 405.751.0011 | f. 405.751.7246

Your Appointment: (please arrive early)

Date:_____

Time:_____

- Dr. Blake Christensen
- Alicia York P.A.-C
- Shannon Medley P.A.-C

**NOTE: If your appointment is a TELEMED APPOINTMENT with one of the providers listed, it is a charge billed to your insurance.

A “co-pay” or a “co-insurance” may apply as per your insurance contract and payment will be due to this office.

You are scheduled to be seen at the following location:

- 13601 Memorial Park Drive, Suite 200
  Oklahoma City, OK 73120

- 3101 W. Tecumseh Road, Suite 102
  Norman, OK 73072

- 1315 N. Washington Avenue
  Weatherford, OK 73096

* Maps and directions to our office can be found at:
www.OklahomaPainTreatmentCenters.com

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PATIENT INFORMATION (Please print – Fill in ALL blanks)					
Patient's Legal Name: Last	First	M.I.	Sex:	DOB:	Age:
Social Security Number:	Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated				
Patient's Address:	Employment Status: ❑Employed ❑Full-Time Student ❑Part-Time Student ❑Retired				
City:	State:	Zip Code:	Email:		
Home Phone:	Work Phone:		Cell Phone:		Referring Physician

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim	
Name of Primary Insurance Company:	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Member ID #
Policyholder Employer:	
Secondary Insurance (if applicable):	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Member ID #
Policyholder Employer:	

EMPLOYMENT INFORMATION	
Patient's Employer:	Phone Number:
Insured Employer:	Phone Number:

If the patient is a minor, please list both parent names and employers

Mother	DOB:	Phone Number:
Father	DOB:	Phone Number:

NEXT-OF-KIN INFORMATION	
Emergency Contact:	
Phone:	Relationship to Patient:

WHO REFERRED YOU TO OUR OFFICE (check one)

❑Adjustor ❑Attorney ❑Billboard ❑Case Manager ❑Doctor ❑Employer ❑Friend
❑Hospital ❑Insurance ❑Magazine ❑Neighbor ❑Phone Book ❑Physical Therapist ❑Coach
❑Radio ❑School ❑Trainer ❑Other

THIRD PARTY BILLING (circle one)		
Is your injury work related?	❑YES	❑NO
Is this injury due to an accident?	❑YES	❑NO
If your injury is MVA related have you obtained an accident report?	❑YES	❑NO

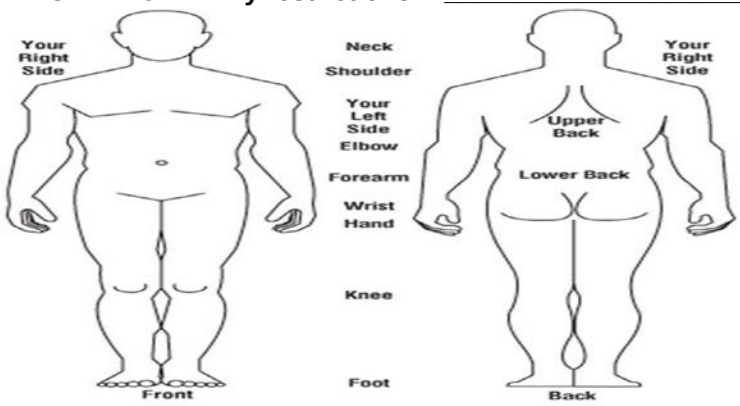
I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the Privacy Notice.

Signature:	Date:

OKLAHOMA PAIN TREATMENT CENTERS

Name: _____ **Date:** _____
Phone: _____ **DOB:** _____ **Age:** _____ **Ht:** _____ **Wt:** _____
Medication Changes Since Last Visit: _____
Reason for Today's Visit: _____
Are you currently working? ❑ **YES** ❑**NO** **Any restrictions?:** _____

On the diagram, check the area(s) where your pain is located:



On a scale from 0 (no pain) to 10 (excruciating) rate your pain:
At its WORST: _____ At its LEAST: _____ At its USUAL: _____ TODAY: _____

QUALITY OF PAIN:

❑ Aching	❑ Pressure	❑ Shooting	❑ Muscle Spasm
❑ Dull	❑ Squeezing	❑ Pins/Needles	
❑ Burning	❑ Tightness	❑ Weakness	
❑ Throbbing	❑ Cramping Muscle Spasm	❑ Coldness	
❑ Sharp	❑ Numbness	❑ Swelling	
❑ Stabbing	❑ Tingling	❑ Loss of Bowel or bladder control?	

Since your last injection or appointment, is your pain: ❑ Improved ❑ Unchanged ❑ Worse

If your pain has improved, please check percentage of improvement:
❑ 10-20% ❑ 20-30% ❑ 30-40% ❑ 40-50% ❑ 50-60% ❑ 60-70% ❑ 70-80% ❑ 80-90% ❑ 90-100%

Since last being seen, do you find it easier to:
❑ WALK ❑ SIT ❑ STAND ❑ BEND ❑ WORK ❑ COOK ❑ CLEAN ❑ SHOP ❑ TRAVEL ❑ DRIVE ❑ RUN ❑ SLEEP ❑ OTHER:

WORSENING FACTORS:

❑ Lifting	❑ Lying Down	❑ Computer/Deskwork
❑ Bending	❑ Standing	❑ During Increased Activity
❑ Squatting	❑ Walking	❑ Stairs
❑ Stooping	❑ Driving	❑ Coughing
❑ Twisting	❑ Reaching	❑ Sneezing
❑ Sitting	❑ Looking Up	❑ Exercise
		❑ House/Yard Work

Are you attending or have attended in the last three months:
❑Physical Therapy -and/or- ❑Manipulation/Chiropractor

If yes, where?:_____
Place Address

Allergies: _____

PATIENT SIGNATURE: _____ **Date:** _____

Current Medications: _____

_____

_____

Past Medical History:

- ❑ Anxiety
- ❑ Depression
- ❑ Mental Disorder
- ❑ Anemia
- ❑ Fibromyalgia
- ❑ Migraines
- ❑ Epilepsy/Seizures
- ❑ Substance Addiction
- ❑ COPD/Emphysema
- ❑ Asthma
- ❑ Sleep Apnea
- ❑ Kidney Stones
- ❑ Kidney Disease
- ❑ Thyroid Disorder
- ❑ HIV/AIDS
- ❑ Glaucoma/Cataracts
- ❑ Arthritis/Rheumatoid
- ❑ Autoimmune Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Disease
- ❑ Stroke/TIA
- ❑ MRSA/Staph Inf.
- ❑ Blood Clots
- ❑ Diabetes
- ❑ Stomach Ulcer
- ❑ Gastritis/Reflux
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Blood/Platelet Dis.

Cancer: _____ Other: _____

Surgical History: _____

_____

_____

_____

Family History:

- ❑ Anxiety
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Stroke
- ❑ Chronic Pain
- ❑ Substance Addiction
- ❑ Heart Disease
- ❑ Depression
- ❑ Other: _____

Social History:

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Alcohol Use: ❑Never ❑Rarely ❑Occasionally ❑Weekly ❑Daily ❑History of Abuse

Tobacco Use: ❑Never ❑Quit ❑Current Smoker ___ Packs per day ❑Smokeless Tobacco

Do you use street drugs or have a history of substance addiction/abuse? ❑ Yes ❑ No

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PRIMARY CARE AND PHARMACY

Patient Name: _____

DOB: _____ Date: _____

Please list your current physicians:

Initial here if medical records can be released to the named physician

1. Primary Care Provider: _____ _____

2. Cardiologist: _____ _____

NOTE:** ANY and ALL medication changes MUST be made during an office visit. There are **absolutely NO EXCEPTIONS

Please list the pharmacy you use on a regular basis

Pharmacy:_____Ph:_____

Location/Address:_____

_____

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CONSENT AND AUTHORIZATION

AUTHORIZATION:

The undersigned patient, legal guardian, or authorizing individual acting on behalf of the patient, understands and agrees to the following:

- BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers reserves the right to perform and administer all care and treatment to the patient.

- Release and Medical Information:

  - Worker's Compensation Patient: BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers is hereby granted by patient authority to release to the insurance carrier, employers, attorney, their representatives or referring physician, all medical information regarding workplace injury in connection with treatment rendered to patient by BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers.

  - Insurance Carrier/Health Maintenance Organization and Governmental Benefits: BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers is hereby authorized to release all medical information necessary to process governmental claims, including, but not limited to Medicare, Medicaid, Tricare, for services rendered by BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers.

  - I acknowledge that BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers generates and maintains electronic medical records. I acknowledge and agree that all such electronic records and any electronic signatures shall have the same force and effect as original written records and signatures. I further acknowledge that I am entitled to a copy of my medical records in paper form upon request and after reasonable payment for such copies.

CONSENT – MEDICAL COLLECTIONS

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

_____ _____

Patient or legal Guardian Signature Date

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DISCLOSURE:

BDC Medical, PLLC, d/b/a Oklahoma Pain Treatment Centers, pursuant to applicable Federal and State laws, makes the following disclosures:

Patient is not required to obtain items or services from any of the following entities which patient may be referred.

DIAGNOSTIC IMAGING SOLUTION, LLC: Dr. Christensen has an investment interest in Diagnostic Imaging Solution, LLC. Patient may obtain alternative services from another provider or any of the following (a) Mercy Health Center 4300 W. Memorial Rd., Oklahoma City, Oklahoma or (b) OCOM 13301 N. Meridian Ave., Suite 600A, Oklahoma City, Oklahoma or (c) any facility that patient requests.

OKLAHOMA SPINE SURGERY CENTER: Dr. Christensen has an investment interest. Patients may obtain services at another facility of their choice.

REMEDY RHEUMATOLOGY: Dr. Christensen has an indirect investment interest in Remedy Rheumatology because Dr. Sarah Alvarez Christensen is his wife. Patients may request a referral to a different rheumatologist.

Financial Responsibility and Authorization: Unless otherwise stated herein, the undersigned shall pay to BDC Medical, PLLC doing business as Oklahoma Pain Treatment Centers such sums which are or may become due for services rendered to or on behalf of patient. If your insurance plan requires authorization from your Primary Care Physician, it is your responsibility to have the authorization at the time of your visit. Without the required information or appropriate authorization, charges may be your responsibility. I understand I may receive services or supplies that are not covered by my insurance plan. I agree to be directly responsible for these expenses. I understand co-pays and services that insurance companies will not cover are due the time of services.

_____ _____

Patient or Legal Guardian Signature Date

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NO SHOW/MISSED APPOINTMENT POLICY

We, at **Oklahoma Pain Treatment Centers**, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least 24-hour notice). You can cancel appointments by calling the following number: **405.751.0011.**

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or text message to you is made/attempted prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least 24 hours' notice. There is a waiting list to see the doctor and clinicians at Oklahoma Pain Treatment Centers and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than 24-hour cancellation is given, it will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment. You are allowed only **one** "No-Show" without a fee.

4. The fee for "No-Show" or same day cancellation, is $200.00 for a procedure and $100.00 for an office appointment.

5. If you have multiple "No-Show/Missed" appointments within a one-year time, dismissal from the practice will be considered.

6. If you are a Worker's Compensation patient or a motor vehicle accident patient, **YOU** are responsible for payment of the "No-Show" fee. This expense cannot be passed on to the insurance company.

I have read and understand Oklahoma Pain Treatment Centers No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Oklahoma Pain Treatment Centers appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

December 2023

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Authorization for the Release of Medical Information/HIPAA OPTC

I certify that the information that I have provided is accurate, complete and true. I authorize OPTC, associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give consent for OPTC to retrieve and review my medication history.

I understand that I have had the opportunity to review OPTC's Notice of Privacy Policy, which is displayed for public inspection at its facility. This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize OPTC to release my protected health information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, my referring physician, primary care physician, and any physician I may be referred to. I also authorize OPTC to release any information required to obtaining procedure authorization or the processing of any insurance claims. I understand that OPTC will not release my protected health information to any other party, including family, without completing a written authorization for us and disclosure of protected health information form available at the facility or in the new patient packet.

_____ _____

Patient of Legal Guardian Signature Date

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HIPAA Privacy Authorization Form

1. Authorization
   I authorize ***Dr. Christensen*** to use and disclose the protected health information described below to _____.

2. Effective Period
   This authorization for release of information covers the period of healthcare from (mm/yy)_____ to (mm/yy) _____. (Release expires twelve months from the date entered below unless this section is completed.)

3. Extent of Authorization
   I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

   OR

   I authorize the release of my complete health record with the exception of the following:

   __Mental Health Records

   __Communicable Diseases

   __Alcohol and Drug Abuse Treatment

   __Other (please specify) _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effective for 12 months at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the Insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name: _____ Date: _____

Signature of patient or personal representative: _____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name **DOB** **SS#**

Address **City, State** **Zip Code**

I hereby authorize _____ to release photocopies of my medical records and/or health information:

___X___ to the following individual and or organization

Oklahoma Pain Treatment Centers
13601 Memorial Park Drive, Suite 200, Oklahoma City OK 73120
Phone 405-751-0011 Fax 405-751-7246

____ **Into my own keeping for personal records**

I further release **Oklahoma Pain Treatment Centers** from the responsibility for any deleterious effect the release of clinical medical records may have upon myself or others, both now and in the future. I personally accept all responsibility for my own distribution and interpretations of medical information contained therein and hold blameless **Oklahoma Pain Treatment Centers** for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By State Law, you must be advised that: ***The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).***

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

Patient's Printed Name **Date**

Patient's Signature **Date**

Signature of person authorized to sign if other than patient **Relationship**

***This authorization shall expire thirty (30) days from the date it was signed by the patient.**

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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, Oklahoma Pain Treatment Centers, 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 preferably before the day of your appointment.

INSURANCE: We will file your insurance claims for all covered services within 2-3 business days of the visit. You will be responsible for any deductible, co-insurance and 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 notify us to issue a refund to the patient.

PAYMENT PLANS: Oklahoma Pain Treatment Center and BDC Medical, PLLC has contracted a collections company to collect all outstanding balances following payment by the insurer. The billing office is willing to set up payment plans if needed. If payments are missed for four (4) consecutive months, your account will be turned to an outside collection agency.

COLLECTIONS: If your account must be sent to a collection agency, additional fees may be incurred as allowed by law.

CO-PAYS: Co-Pays are billed for Telemedicine Appointments Scheduled with Dr. Christensen or with one of the Physician Assistants, because you are scheduled with a licensed medical provider. Physician Assistants are licensed medical providers!

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 and Oklahoma Pain Treatment Center and BDC Medical, PLLC, 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 understand that I will be held responsible for payment at the settlement of my case and if I do not pay in a timely manner, my account may be sent to an outside collection agency.

I HAVE READ AND UNDERSTAND THE OKLAHOMA PAIN TREATMENT CENTERS AND BDC MEDICAL, PLLC FINANCIAL POLICY OUTLINED ABOVE.

Patient Signature **Date** Dec. 2023

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CONFIDENTIAL AUTHORIZATION FOR CREDIT/DEBIT CARDS

Patient Name: _____Date of Birth: ____/____/_____

Name on Credit/Debit Card: _____

Credit/Debit Card Number:_____3-digit Security Code:_____

Expiration Date: _____ VISA MASTERCARD DISCOVER

AMERICAN EXPRESS

Address where your credit/debit card statement is mailed:

_____

_____

_____

WE MUST MAKE A COPY OF YOUR DRIVER'S LICENSE

Telephone Numbers:

Home:_____Cell:_____Work: _____

The office of Oklahoma Pain Treatment Centers is authorized to keep my signature on file and charge my credit/debit card account for any outstanding balances for out-of-pocket expenses for services rendered as per my agreement and contract with the Doctor.

I understand and agree with this office policy.

Cardholder's signature:_____Date: _____

Because the cost of most procedures, injections, casts, durable medical goods, etc. is applied to the deductible amount of your insurance plan, you will be responsible for these charges at today's visit.

Our staff will inform you of these charges before services are performed to allow you to decide which treatments or procedures you select.