MICHIGAN ORTHOPAEDIC SPINE SURGEONS

1555 E. South Blvd. #310 Rochester Hills, MI 48307
Phone (248)215-8080 Fax (248)289-1085

OFFICE POLICIES

We have reserved_____ for you to have a consultation with:

Richard W. Easton, M.D.	Brent Lotterman PA-C
Bradley D. Ahlgren, M.D.	Michael Broad PA-C
Brady T. Vibert, M.D.	Brandon Mackenzie PA-C
Nicholas S. Papakonstantinou, M.D.	Thomas Klick Jr. PA-C
John S. Papakonstantinou, M.D.	Brett Schulte PA-C
Nathan A. Rimmke, M.D.	Matthew Cain PA-C
Scott M. Diamond, M.D.	

Please complete forms prior to appointment time. If you are unable to complete the forms arrive 15 minutes early for your appointment to ensure sufficient time for registration, insurance verification etc.

All co-pays, deductibles or outstanding balances are due at the time of check-in

Please bring the following information to your appointment:

1. Photo ID and all insurance cards
2. CD with imaging (x-ray's, MRI, Ct scan, Myelograms)
3. An updated medication list with the dose and frequency
4. If a referral or authorization is needed, and not submitted at the time of your visit, your appointment may be rescheduled.
5. If this is a Workers Compensation or Auto Claim, a Letter of Authorization, Open Claim Letter, or Notice of Dispute is needed **prior to your appointment**. Without this information your appointment will be rescheduled.
6. Any applicable insurance which is **NOT** disclosed at the time of appointment will not be processed or billed later.

Failure to have this information may cause your appointment to be rescheduled.

If you need to cancel your appointment, please contact our office (248) 215-8080. If you arrive late to your scheduled appointment time, your appointment may be rescheduled at the discretion of our doctors.

I acknowledge that I have read and/or received a copy of this policy. I agree to the terms listed within.

SIGNATURE: _____Date:_____

MICHIGAN ORTHOPADEDIC SPINE SURGEONS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices from Michigan Orthopaedic Spine Surgeons. (Located at check-in)

_____

Name of Patient (Print)

_____

Signature of Patient Date

_____

Name of Patient Representative (Print or Type) Relationship

_____

Signature of Patient Representative Date

(Required if the patient is a minor or an adult who is unable to sign this form)

Additional Authorization (i.e.: spouse, close relative, trusted friend, etc.)

I give the following person(s) permission to have access to my medical and financial information:

_____

Name (Print or Type) Relationship

_____

Signature of Patient Date

MICHIGAN ORTHOPAEDIC SPINE SURGEONS

PATIENT INFORMATION SHEET

PATIENT NAME: _____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

HOME ADDRESS: _____
(NUMBER) (STREET) (CITY) (STATE) (ZIP)

BIRTH DATE: _____ **AGE** _____ **SEX: Male/Female (circle one)**

SOCIAL SECURITY #: _____

MARITAL STATUS: Single / M / W / D EMAIL ADDRESS: _____

PHONE NUMBER TO REACH YOU: _____

WORK #: _____

PREFERRED METHOD OF COMMUNICATION: CELL HOME OTHER

EMERGENCY CONTACT:

NAME: _____ **RELATIONSHIP:** _____

PHONE: _____

PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR): _____

PATIENT EMPLOYMENT STATUS (CIRCLE) FULL TIME / PART TIME / NOT EMPLOYED / RETIRED / DISABLED

STUDENT STATUS (IF APPLICABLE – CIRCLE) FULL TIME / PART TIME / NOT A STUDENT

PATIENT EMPLOYER: _____

PATIENT OCCUPATION: _____ **PRESENTLY EMPLOYED? YES / NO**

RESPONSIBLE PARTY INFORMATION: (under the age of 18/holder of insurance) **RELATIONSHIP TO PT:** Mother / Father

NAME: _____ SEX: MALE / FEMALE

ADDRESS: _____
(NUMBER) (STREET) (CITY, STATE, ZIP)

PHONE #: (_____) _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

EMPLOYER: _____ PHONE #: (_____) _____

MICHIGAN ORTHOPAEDIC SPINE SURGEONS

PATIENT INFORMATION C0NTINUED PAGE 2

WHAT PROVIDER ARE YOU SEEING TODAY? _____

REASON FOR SEEKING CARE? _____

DATE OF INJURY OR ONSET: _____ **HOW DID IT HAPPEN?** _____

IS THIS INJURY DUE TO AN AUTO ACCIDENT? YES / NO DID THIS INJURY HAPPEN AT WORK? YES / NO

REFFERED BY: _____

FAMILY DOCTOR/PCP: _____ **PHONE #: (_____)** _____

ADDRESS: _____
(NUMBER) (STREET) (CITY, STATE, ZIP)

I CONFIRM THIS INFORMATION IS COMPLETE AND ACCURATE:

PATIENT OR REPRESENTAITIVE SIGNATURE: _____

MICHIGAN ORTHOPAEDIC SPINE SURGEONS

MEDICAL INSURANCE INFORMATION

Patient Name:_____
(First) **(Middle)** **(Last)**

Primary Insurance Name: _____

Subscriber's Name: _____ **Date of Birth:** _____

Employer: _____ **Retired?** _____ **When:** _____ _____

Secondary Insurance Name: _____

Subscriber's Name: _____ **Date of Birth:** _____

Employer: _____ **Retired?** _____ **When:** _____ _____

Third Insurance Name: _____

Subscriber's Name: _____ **Date of Birth:** _____

Employer: _____ **Retired?** _____ **When:** _____

Workers Comp/ Auto: Employer/Subscriber: _____

Name of Insurance Co: _____ **Phone (_____)** _____

Address: _____ **City:** _____ **State:** ___ **Zip:**_____

Claim# _____ **Name of Adjuster:** _____

MICHIGAN ORTHOPAEDIC SPINE SURGEONS

Should your account become delinquent

To comply with Government Regulation F, we must inform you of the following:

By signing below, you agree that MOSS ORTHOPAEDIC SPINE SURGEONS including any business associates may contact you by telephone at any telephone number provided by you or associated with your records. This may include cell phone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the contact information you provided. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.**

****What Is a "Business Associate?"** A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information (PHI) on behalf of, or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate.

I choose to comply with Regulation F

_____

Sign and date

I choose to OPT OUT of Regulation F

_____

Sign and date

Patient Financial Information

BCBS/COMMERCIAL/WORKERS COMP/AUTO INSURANCE PATIENTS-*PLEASE READ AND SIGN BELOW:*

I authorize the release of medical information necessary to process my claims and authorize payment of medical benefits to Michigan Orthopaedic Spine Surgeons, P.C. for services rendered and authorize to the Health Care Financing Administration information needed to determine these benefits. I understand I will be responsible for all co-pays, co-insurance and deductibles not covered by my insurance(s).

Print Patient Name	Date of Birth
Patient or Representative Signature	Date

IF MEDICARE IS YOUR PRIMARY INSURANCE - *PLEASE READ AND SIGN BELOW*:

I, _____Medicare # _____
request payment of authorized Medicare benefits to be made on my behalf to Michigan Orthopaedic Spine Surgeons, P.C. for services rendered and authorize to the Health Care Financing Administration information needed to determine these benefits. I understand I will be responsible for all co-pays, co-insurance and deductibles not covered by my insurance(s).

Print Patient Name	Date of Birth
Patient or Representative Signature	Date

Michigan Orthopaedic Spine Surgeons
Credit Card Policy

This is strictly voluntary
Credit Card Financial Policy

To our patients: many businesses request a credit card at the time of service. MOSS has implemented a similar policy; you can authorize MOSS to charge your credit card for your balance due. This would only take place after your medical charges were submitted to your insurance carrier(s) and the insurance company has paid MOSS. We believe this will ease the billing process for you as well as MOSS with elimination of repeated statements and can result in lower health care costs. Patients can dispute a charge or question your insurance companies' determination of payment.

Co-pays, co-insurance, and deductible amounts will continue to be due at the time of your visit.

May we implement this policy for you?

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK

I authorize Michigan Orthopaedic Spine Surgeons to charge outstanding balances on my account to the following credit card:

VISA ____ Mastercard _____ American Express _____ Other ____

Card number _____Expiration Date _____

Name on Card _____

CVC _____ billing zip code _____

Signature _____ Date _____

MICHIGAN ORTHOPAEDIC SPINE SURGEONS

E-PRESCRIBING TO YOUR PHARMACY

(Allows your prescription to be electronically sent to your pharmacy)

Patient Name: _____ DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____