

Michigan Surgery Specialists, P.C.

Notice of Privacy Practices

Acknowledgement/Good Faith Effort Form

11012 Thirteen Mile Road, Suite 201

Warren, Michigan 48093

Phone (586) 582-0760 Fax (586) 582-5729

<i>Guy P. Pierret, M.D.</i>	<i>Edward F. Burke, D.O.</i>	<i>Richard M. Singer, M.D.</i>
<i>Mehul M. Mehta, M.D.</i>	<i>Robert S. Barbosa, D.O.</i>	<i>Mark A Olson, M.D.</i>
<i>Samson P. Samuel, M.D.</i>	<i>John R. Wagner, Jr., M.D.</i>	<i>Jeffrey M. Hall, M.D.</i>
<i>Jeffrey E. Gorosh, D.O.</i>	<i>Carlos M. Villafane, M.D.</i>	<i>Saleem A. Tahir, M.D.</i>
<i>Steven T. Plomaritis, D.O.</i>	<i>John B. Ryan, M.D.</i>	<i>Ronald T. Rook, D.O.</i>
<i>Michael E. Tofteland, M.D.</i>	<i>E. Aron L. Haass, D.O.</i>	<i>Peter M. Nefcy, M.D.</i>
	<i>Albert H. Belfie, D.O.</i>	

Patient Name: _____ **Patient Account:** _____

Affiliated Entities Covered by this Acknowledgement/Good Faith Effort:

- Hand Surgery Associates of Michigan, P.C.
- Greater Michigan Orthopaedics & Sports Medicine
- Michigan Hand & Sports Rehabilitation Centers
- LifeScan Imaging of Michigan

Acknowledgement:

I acknowledge that I have received the Privacy Practices from Michigan Surgery Specialists, P.C.

Patient or Personal Representative

Date

Signature

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

Please tell us which family members or (emergency contact) we may speak with concerning your medical information

Name: _____ **Relationship:** _____ **Telephone #:** _____

Name: _____ **Relationship:** _____ **Telephone#:** _____

Good Faith Effort:

The above patient presented for treatment on this date, _____, and was provided with a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice of Privacy Practices. However, an acknowledgement was not obtained because:

-- Patient refused to sign.

-- Patient was unable to sign or initial because: _____

-- There was a medical emergency and the practice will attempt to obtain an Acknowledgement at the next available opportunity.

-- Other: _____

Employee Name: _____ Employee Signature: _____

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ASSIGNMENT OF BENEFITS MEDICAL INFORMATION AND PHOTOGRAPHY RELEASE

Patient Name

Insurance Policy Holder Name

Patient Date of Birth

Subscriber's Relation to Patient

I hereby authorized payment directly to **Greater Michigan Orthopaedics and Sports Medicine, P.C.** for all medical and surgical, basic, and/or medical otherwise payable to me for all treatment of the above named patient. I understand that I am financially responsible for charges to said corporation for charges not covered by my policy. I further authorized the physician to release information requested by my insurance company in order to verify and process said claim(s).

Also, by my signature I authorized to **Greater Michigan Orthopaedics and Sports Medicine, P.C.** release to the Employer, Compensation/Insurance Carrier, and/or Referring Physician any and all records or reports pertaining to the medical treatment. This will also authorize release of necessary reports to any physician to whom the patient is referred.

I am also aware that **Greater Michigan Orthopaedics and Sports Medicine, P.C.** may obtain photographs of my body for scientific, medical, and/or legal purposes. My signature authorizes use of these photographs in this manner.

I understand that for a successful Physician/Patient relationship it is important for me as a Patient to return for scheduled appointments and comply with the Physician's medical instructions and otherwise cooperate with my Physician. The Physicians of **Greater Michigan Orthopaedics and Sports Medicine, P.C.** reserve the right to discontinue permanently or temporarily the Physician/Patient relationship in the event that the relationship is impaired as a result of my action or inaction.

Date

Signature of Patient/Subscriber (Parent/Guardian if Minor)

Date

Witness- Greater Michigan Orthopaedics and Sport
Medicine, P.C. -Employee Signature

PLEASE PRINT CLEARLY & COMPLETE FULLY

Date: _____ Patient Account #: _____ Doctor: _____

Patient Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Sex: _____ Social Security #: _____

Home Phone # (____) _____ Mobil/Cellular #: (____) _____

Pager #: (____) _____ Check One: Married _____ Single _____ Divorced _____ Widowed _____

In Case of an Emergency Contact:

Name: _____ Phone #: (____) _____ Relationship: _____

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

Employer: _____ Occupation: _____ Phone #: (____) _____

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

How Long with this Employer? _____ Missed any work due to injury/problem? _____ Date last worked? _____

REFERRING PHYSICIAN

FAMILY PHYSICIAN

Name: _____

Name: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Phone #: (____) _____

Phone #: (____) _____

This problem/injury is related to which of the following: Employment () Auto Accident () Other () _____

Is this problem an injury or something that has developed? Injury: _____ Developed: _____

If injury/problem is work related, has your employer been informed? Yes () No () Has a claim been filed? Yes () No ()

Date of injury or date problem first noticed: _____ Patient's Dominant Hand: Right () Left ()

() Knee () Shoulder () Ankle () Elbow () Wrist: Right () Left ()

Describe your problem; if injury, how it happened: _____

PLEASE RETURN THIS FORM WITH INSURANCE CARDS,
DRIVER'S LICENSE AND ANY AUTHORIZATIONS
INSURANCE INFORMATION

Medical History Section of form is NOT fillable.
 Please check by hand the Medical History Section of this form.

NAME: _____
 DOCTOR: _____
 DATE: _____

REFERRAL #: _____
 PATIENT #: _____

NEW PATIENT

I. CHIEF COMPLAINT (Explain, in your own words, what your problem is.)

Dominant Side: RT LT
 Injured Side: RT LT
 HT: _____ WT: _____
 Smoker: Yes No
 # Packs/Day: for _____ years
 Pregnant: Yes No
 LMP: _____

II. HISTORY OF CHIEF COMPLAINT

III. MEDICAL HISTORY

Please check YES or NO. If there is more than one choice, circle the one that pertains:

YES/NO

- High Blood Pressure
- Heart Attack/Heart Disease
- Rheumatic Fever/Heart Murmur
- Chest Pain
- Shortness of Breath/Cough
- Bronchitis/Emphysema/Asthma
- Tuberculosis/Pneumonia/Lung Disease
- On a special weight-reduction diet
- Hepatitis/Jaundice/ Liver Disorders
- Problems with opening mouth wide
- Hiatal Hernia/Ulcers/Gastritis
- Diabetes
- Stroke
- Spells/Migraines
- Dizziness/Weakness
- Steroids
- Seizures/Fits
- Sciatica/Back Problems/Slipped Disk
- Arthritis/Neck Problems
- Kidney Disease
- Thyroid Disease/Goiter
- Anemia/Sickle Cell Disease
- Thyroid Disease
- Cataracts
- Bleeding Problems/Blood Clots

YES/NO

- Do you drink alcohol? How much? _____
- Recent Cold or Sore Throat
- History of Drug Abuse
- Mental Illness
- Cancer
- Chemotherapy
- AIDS/HIV
- Anesthesia Reactions
- Medications (If yes, please list) _____
- _____
- _____
- Allergies (If yes, please list) _____
- _____
- _____
- Birth Control Pills
- Surgeries (If yes, please list) _____
- _____
- Any other medical problems _____
- _____
- _____

IV. FAMILY HISTORY: PLEASE CIRCLE ONE FILL IN MEDICAL HISTORY

FATHER: LIVING/DECEASED MEDICAL HISTORY: _____
MOTHER: LIVING/DECEASED MEDICAL HISTORY: _____
BROTHERS: # _____ LIVING # _____ DECEASED MEDICAL HISTORY: _____
SISTERS: # _____ LIVING # _____ DECEASED MEDICAL HISTORY: _____

PRIMARY INSURANCE: _____ Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Group #: _____ ID/Contract #: _____ Effective Date: _____
Plan Code #: _____ Service Code #: _____
Patient's Relationship to the Insured Party: Self () Spouse () Dependent () Other ()
Insured's Name: _____ Insurer's Date of Birth: _____
Insured's Social Security #: _____ Insured's Home Phone #: (____) _____
Insurer's Address: _____ City: _____ State: _____ Zip: _____
Insurer's Employer Name: _____ Work Phone #: (____) _____

SECONDARY INSURANCE: _____ Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Group#: _____ ID/Contract #: _____ Effective Date: _____
Plan Code #: _____ Service Code #: _____
Patient's Relationship to the Insured Party: Self () Spouse () Dependent () Other ()
Insured's Name: _____ Insured's Date of Birth: _____
Insurer's Social Security #: _____ Insured's Home Phone #: (____) _____
Insurer's Address: _____ City: _____ State: _____ Zip: _____
Insurer's Employer Name: _____ Work Phone #: (____) _____

AUTO INSURANCE: _____ Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Claim #: _____ Date of Injury: _____
Claim Representative's Name: _____ Phone #: (____) _____ Ext #: _____

WORKER'S COMPENSATION: _____ Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Claim #: _____ Date of Injury: _____
Contact Person's Name at Employer: _____ Phone #: (____) _____ Ext #: _____
Claim Representative's Name: _____ Phone # (____) _____ Ext #: _____