

BLUE CROSS INSURANCE

Subscriber's Name _____
Group # _____ Service Codes _____
Contract # _____ Plan Code _____
Preauthorization # _____ Reciprocity # _____

MEDICARE INSURANCE

Medicare Identification # _____
Hospital Effective Date _____ Medical Effective Date _____

MEDICAID INSURANCE

Medicaid ID # _____ Primary Doctor Phone # _____
Primary Sponsor _____ ID # _____ Type _____
Address _____

COMPENSATION / PRIVATE

Name _____ Code # _____
Address _____
Contact Person _____ Phone # _____
ID/Contract # _____ Group # _____

HMO

Name _____ Code # _____
Address _____
Phone _____ Primary Physician _____
Member # _____ Address _____
Group # _____
ID # _____ Phone _____

Michigan Surgery Specialist, P.C.

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Peter M. Nefcy, M.D.

Date: _____

Patient # _____
To be completed by office

Physician: _____
*Plastic & Reconstructive Surgery
Surgery of the Hand*

PATIENT INFORMATION:

(Please Print)

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Age _____ Male _____ Female _____ SS#: _____

Address: _____
Street City State Zip Code

Home Phone #: (____) _____ Work: (____) _____ Cell: (____) _____

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

Spouse's Name: _____ **Check One:** Married Single Divorced Widowed

Emergency Contact: _____

Emergency Contact Phone #: (____) _____ Relationship: _____

Parent / Guardian (Patient under 18 or incapacitated): _____

INSURANCE INFORMATION:

Primary Insurance: _____

Subscriber Name: _____ Date of Birth: _____ SS#: _____

Subscriber's Employer: _____ Group #: _____

Secondary Insurance: _____

Subscriber Name: _____ Date of Birth: _____ SS#: _____

Subscriber's Employer: _____ Group #: _____

Reason for Today's Visit _____

REFERRED BY: _____

Signature; Patient / Responsible party

Date

Michigan Surgery Specialists, P.C.

***Macomb Medical Specialists Building
11012 Thirteen Mile Road, Suite 112
Warren, Michigan 48093
(586) 573-6880 Fax: (586) 573-2562***

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HMO INSURANCE GUIDELINES

DEAR PATIENT:

Under the guidelines of your insurance company, all services that are rendered to you must receive prior authorization from your PRIMARY CARE PHYSICIAN (PCP).

At the time of your appointment, we will need authorization for:

**OFFICE VISITS
CASTING
X-RAYS
PIN REMOVAL
INJECTION
FRACTURE CARE**

Only the services that are performed will be billed; however, it is easier to have this authorization prior to your appointment rather than trying to contact your PCP when you arrive for your appointment.

If you have any questions as to what services might be performed and which procedures should be included on the referral, please ask the clinical department.

A referral must be obtained for each date of service you are seen and must include the above services that may be performed. If our office does not receive authorization to perform these procedures, your appointment may have to be rescheduled.

Thank you for your cooperation,

HAND SURGERY ASSOCIATES OF MICHIGAN, P.C.

Michigan Surgery Specialists, P.C.

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Warren, Michigan 48093
Phone (586) 573-6880 Fax (586) 573-2562*

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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 **HAND SURGERY ASSOCIATES OF MICHIGAN** 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 **HAND SURGERY ASSOCIATES OF MICHIGAN** to 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 **HAND SURGERY ASSOCIATES OF MICHIGAN** 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 **HAND SURGERY ASSOCIATES OF MICHIGAN** 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-Hand Surgery Associates of Michigan-Employee Signature

Medical History Section of form is NOT FILLABLE.
 Please Check by hand the Medical History Section
 of this form and section marked with RED ASTERIK(*).

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		YES/NO	
<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Do you drink alcohol? How much? _____
<input type="checkbox"/> <input type="checkbox"/>	Heart Attack/Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	Recent Cold or Sore Throat
<input type="checkbox"/> <input type="checkbox"/>	Rheumatic Fever/Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	History of Drug Abuse
<input type="checkbox"/> <input type="checkbox"/>	Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Mental Illness
<input type="checkbox"/> <input type="checkbox"/>	Shortness of Breath/Cough	<input type="checkbox"/> <input type="checkbox"/>	Cancer
<input type="checkbox"/> <input type="checkbox"/>	Bronchitis/Emphysema/Asthma	<input type="checkbox"/> <input type="checkbox"/>	Chemotherapy
<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis/Pneumonia/Lung Disease	<input type="checkbox"/> <input type="checkbox"/>	AIDS/HIV
<input type="checkbox"/> <input type="checkbox"/>	On a special weight-reduction diet	<input type="checkbox"/> <input type="checkbox"/>	Anesthesia Reactions
<input type="checkbox"/> <input type="checkbox"/>	Hepatitis/Jaundice/ Liver Disorders	<input type="checkbox"/> <input type="checkbox"/>	Medications (If yes, please list) _____
<input type="checkbox"/> <input type="checkbox"/>	Problems with opening mouth wide		_____
<input type="checkbox"/> <input type="checkbox"/>	Hiatal Hernia/Ulcers/Gastritis		_____
<input type="checkbox"/> <input type="checkbox"/>	Diabetes		_____
<input type="checkbox"/> <input type="checkbox"/>	Stroke		_____
<input type="checkbox"/> <input type="checkbox"/>	Spells/Migraines	<input type="checkbox"/> <input type="checkbox"/>	Allergies (If yes, please list) _____
<input type="checkbox"/> <input type="checkbox"/>	Dizziness/Weakness		_____
<input type="checkbox"/> <input type="checkbox"/>	Steroids		_____
<input type="checkbox"/> <input type="checkbox"/>	Seizures/Fits		_____
<input type="checkbox"/> <input type="checkbox"/>	Sciatica/Back Problems/Slipped Disk	<input type="checkbox"/> <input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/> <input type="checkbox"/>	Arthritis/Neck Problems	<input type="checkbox"/> <input type="checkbox"/>	Surgeries (If yes, please list) _____
<input type="checkbox"/> <input type="checkbox"/>	Kidney Disease		_____
<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disease/Goiter		_____
<input type="checkbox"/> <input type="checkbox"/>	Anemia/Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/>	Any other medical problems _____
<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disease		_____
<input type="checkbox"/> <input type="checkbox"/>	Cataracts		_____
<input type="checkbox"/> <input type="checkbox"/>	Bleeding Problems/Blood Clots		_____

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: _____

Michigan Surgery Specialists, P.C.

Notice of Privacy Practices

Acknowledgement/Good Faith Effort Form

11012 Thirteen Mile Road, Suite 112

Warren, Michigan 48093

Phone (586) 573-6880 Fax (586) 573-2562

<i>Guy P. Pierret, M.D.</i>	<i>Edward F. Burke, D.O.</i>	<i>Richard M. Singer, M.D.</i>
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	<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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INJURY/ACCIDENT DETAIL FORM

Please provide the following information below so we may file this form with your insurance company for prompt payment. If the questions do not apply, please enter not apply or "N/A", be sure to sign and date at the bottom of form. **PLEASE PRINT CLEARLY AND ANSWER ALL QUESTION'S.** Thank you for your time.

Patient Name: _____ Today's Date: _____

Patient's Home Phone #: (____) _____ Work #: (____) _____

Name of Insurance Co: _____ ID #: _____

Date of Injury/Accident: _____ Work Related? Y _____ N _____ Auto Related? Y _____ N _____

Where Did Injury/Accident Happen?

How Did Injury/Accident Happen? _____

Do you intend to seek reimbursement from a third party? Y _____ N _____

If you have consulted an attorney, please provide the name & address of attorney:

_____ Phone: (____) _____

Name and address of responsible party for the injury/accident: _____

If this was an auto accident, please provide the following:

Name & Address of Auto Insurance:

Auto Insurance Phone #: (____) _____ Policy #: _____

Amount of Medical Coverage on Auto Policy:

\$ _____

Amount of Uninsured/underinsured Motorist Coverage:

\$ _____

Signature (Parent or Guardian, if Minor)

Date

Updated 09/22/11 MSS PC Logo-sk