

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
Matthew L. D'John, 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 or deductibles 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. A referral or authorization, if needed. If not obtained by the time of your visit, your appointment will 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 relevant insurance **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 ORTHOPAEDIC 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

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

Date

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 SPRINE & 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 CONTINUED 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

REFERRED BY: _____

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

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

I CONFIRM THIS INFORMATION IS COMPLETE AND ACCURATE:

PATIENT OR REPRESENTATIVE 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

Patient Financial Information

MEDICARE BENEFICIARIES - *PLEASE READ AND SIGN BELOW:*

I, _____ Medicare # _____
request payment of authorized Medicare benefits 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).

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

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 has been 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 results 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 medications to be electronically submitted to your pharmacy)

Patient Name: _____ DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____