

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
Christopher A. Hulen, M.D.	Thomas Klick Jr. PA-C
Nicholas S. Papakonstantinou, M.D	
John S. Papakonstantinou, M.D	
Nathan A. Rimmke, M.D	

Please take the time to fill out the enclosed forms completely. Failure to do so may delay your visit. Please **ARRIVE AT YOUR SCHEDULED APPOINTMENT TIME** to allow time for our staff to verify all insurance and paper work.

If you have a co-pay or deductible, payment is due at the time of check in.

Please obtain all testing from your referring doctor and/or primary care physician. You will also need to bring any X-rays, CDs of MRIs, CT Scan, Myelograms. Failure to do so may cause your appointment to be rescheduled.

Other required information to bring to your appointment;

1. Photo ID
2. All insurance cards
3. An updated medication list with the dose and frequency
4. A referral or authorization if one is 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 or 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 at a later date.

If you need to cancel your appointment, please contact our office. 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: _____

Effective Date: April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Michigan Orthopaedic Spine Surgeons

Richard W. Easton, M.D.
Bradley D. Ahlgren, M.D.
Brady T. Vibert, M.D.
Christopher A. Hulen, M.D.
Nicholas S. Papakonstantinou, M.D.
John S. Papkonstantinou, M.D.
Nathan A. Rimmke, M.D.

I have received a copy of the Notice of Privacy Practices for the above named physicians.

Name of Patient (Print or Type)

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

In addition to the practices outlined in our Privacy Notice, I gave the above named physicians my authorizations to release my personal medical and or financial information to:

Name (Print or Type)

Relationship

Patient Signature

Date

PATIENT INFORMATION SHEET

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

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

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

HOME PHONE: (_____) PATIENT BIRTH DATE: _____ AGE: _____ SEX: _____

PATIENT SOCIAL SECURITY #: _____ MARITAL STATUS (CIRCLE) S M W D

PATIENT EMPLOYMENT STATUS (CIRCLE) Full Time / Part Time / Not Employed / Retired - Date _____

STUDENT STATUS (if applicable - Circle) Full Time / Part Time / Not a Student

PATIENT EMPLOYER _____ PHONE NO. (_____)

PATIENT OCCUPATION _____ PRESENTLY EMPLOYED? YES / NO

EMERGENCY CONTACT (SOMEONE NOT LIVING WITH YOU)

NAME: _____ RELATIONSHIP: _____ PHONE: (_____)

RESPONSIBLE PARTY INFORMATION : (IF OTHER THAN PATIENT) RELATIONSHIP TO PT: _____

NAME: _____ SEX: MALE / FEMALE

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

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

EMPLOYER: _____ PHONE: (_____)

REASON FOR SEEING DOCTOR: _____

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)

PLEASE GIVE THE RECEPTIONIST THE FOLLOWING:

- 1) ALL your insurance cards
- 2) Driver's License/Picture ID
- 3) X-rays/Reports
- 4) Your HMO referral (if applicable)
- 5) Your Workers Comp Letter of Authorization (if applicable)

I confirm that all the information furnished is complete and accurate as of: _____
(Date)

PATIENT OR GUARDIAN SIGNATURE: _____

MEDICAL INSURANCE INFORMATION

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:** _____

MEDICARE PATIENTS- 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 furnished and authorize to the Health Care Financing Administration any information needed to determine these benefits. I understand I will be responsible for all co-pays and deductibles not covered by my insurance(s).

COMMERCIAL/BCBS/WORKERS COMP/AUTO INSURANCE PATIENTS- PLEASE SIGN BELOW

I authorize the release of medical information necessary to process my claims and also authorize payment of medical benefits to Michigan Orthopaedic Spine Surgeons, P.C. for services furnished to me (or my dependent if a minor). Commercial/BCBS- I also understand that I will be responsible for all my co-pays and deductibles not covered by my insurance(s).

Print Patient Name

Patient Date of Birth

Patient/Parent Signature

Date

Date: _____

E-PRESCRIBING

**To allow your medications to be electronically submitted to your
pharmacy.**

Patient Name: _____

Patient Date of Birth: _____

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone #: _____

PAIN SCALE

(PLEASE USE SCALE FOR FOLLOWING QUESTIONS)

	SYMPTOMS
1 (ONE)	Pain free
2 (TWO)	Very minor annoyance—I have occasional minor twinges
3 (THREE)	Annoying enough to be distracting
4 (FOUR)	Can be ignored if busy, but still distracting
5 (FIVE)	Can't be ignored for more than 30 minutes
6 (SIX)	Can't be ignored for any length of time but can still work and do social activities
7 (SEVEN)	Makes it difficult to concentrate, interferes with sleep, can function with effort
8 (EIGHT)	Physical activity severely limited, can read and speak with effort, experience nausea and dizziness
9 (NINE)	Unable to speak, crying out or moaning uncontrollably
10 (TEN)	Either unconscious or it makes you want to pass out

**PLEASE COMPLETE ALL FORMS FOR
YOUR APPOINTMENT**

Michigan Orthopaedic & Spine Surgeons
Nathan A. Rimmke, M.D.
Initial Visit

Patient's name: _____ **Date of Birth:** _____ **Today's Date:** _____

Primary Medical Physician: _____ **Referring Physician:** _____

Age: _____ **Height:** _____ **Weight:** _____

Complaint or Problem: Left Right Bilateral
 Shoulder Elbow Hip Knee Ankle Other: _____

Hand Dominance: Left Right Ambidextrous

Duration: date of onset: ___ days, ___ weeks, ___ months, ___ years, continuous since onset
add'l notes _____

Mechanism of Injury: cannot identify, fall, bending, lifting, twisting, sports injury, work injury,
MVA, assault, overuse, atraumatic, laceration add'l notes _____

Felt or heard "pop": yes no n/a

Immediate Swelling: yes no n/a

Timing: cannot identify, acute, chronic, abrupt, gradual, morning, daytime, nighttime, recurrent,
rare, occasional, intermittent episodes lasting: _____ add'l notes _____

Location: anterior, posterior, medial, lateral, deep, superficial, add'l notes _____

Does Pain Radiate? no yes if yes, where? _____

Character of Pain: aching, burning, stabbing, throbbing, sharp, dull, occasional, frequent,
constant, intermittent, worsening, improving, no change, add'l notes _____

Severity: no pain, mild, moderate, severe, current pain level ___/10, worst pain level ___/10
add'l notes _____

Aggravating Factors: cannot identify, lifting, carrying, twisting, pivoting, pushing/pulling,
gripping, throwing, walking, running, weight-bearing, exercise, sports, work, previous surgery,
daily activities of living, changing clothes, combing hair, getting out of bed, going from sit to
stand, going up or down stairs, morning, daytime, nighttime, cold weather, certain positions of
arm or leg: _____ add'l notes _____

Alleviating Factors: nothing helps, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractic care, OTC medication, narcotics, NSAIDs, cortisone injections, visco-supplementation injections, orthotics, previous surgery, brace, splint, sling, add'l notes _____

Associated Symptoms: weakness, numbness, tingling, swelling, redness, warmth, ecchymosis, drainage, fever, chills, weight loss, change in bowel/bladder habits, rash and skin lesion, nosebleeds, sore throat, blurred vision, chest pain, dyspnea on exertion, cough, nausea, vomiting, headaches, hallucination, insomnia, bruises/bleeds easily, lymph node swelling, hot flashes, sweats, add'l notes _____

Mechanical Symptoms: clicking, popping, locking, catching, none, add'l notes _____

Instability Episodes: unstable, buckling, giving out, dislocated, none, add'l notes _____

If Dislocated: how many times? _____ physician assisted reduction? _____

Swelling History: none, continuous, occasional, frequent, after what activities? _____

Previous Treatment:

Previous PT: none, did not help, helped a little, helped temporarily, helped significantly add'l notes _____

Previous Cortisone Injections: none, did not help, helped a little, helped temporarily, helped significantly add'l notes _____

Previous Visco-supplementation Injections: none, did not help, helped a little, helped temporarily, helped significantly add'l notes _____

Previous Surgery: none, surgical procedure: _____ date: _____ add'l notes _____

Prior Imaging: none, no recent studies, x-ray, MRI, CT scan, bone scan, EMG add'l notes _____

Occupation: _____ **Work Related:** no, yes add'l notes _____

Working: no, regular duty, modified duty add'l notes _____

Activities: _____

Medication Record

Patient Name: _____ Date of Birth: _____

Physician prescribing pain medication/pain management physician: _____

Name of Medication (Prescriptions, over the counter eye drops, supplements, patches, herbals, inhalers, implanted pumps)	Dose of Medication (Example: one 20mg tablet)	How Often Do You Take This Medication? (Examples: three times a day, at bedtime)

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Pain Management Specialists
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Rochester Hills Mi, 48307

248-215-8080 FAX:248-289-1085

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