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 Papakonstantinou, M.D
John Papkonstantinou, 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

_____
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- PLEAE 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).

COMMERICAL/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 #:_____

Michigan Orthopaedic Spine Surgeons
John S. Papakonstantinou, M.D.
Initial Visit

Patient's name:_____ **Date:** _____

Complaint or Problem:

_____

_____

Hand Dominance: left, right, ambidextrous addt'l notes_____

Location: left, right, bilateral, anterior, posterior, medial, lateral, deep, superficial, radial, ulnar, dorsal, volar addt'l notes_____

Quality: aching, burning, gnawing, stabbing, throbbing, sharp, dull, superficial, deep, occasional, frequent, constant, worsening, improving, no change addt'l notes_____

Severity: no pain, mild, moderate, severe, pain level ___/10, worst pain ___/10 addt'l notes_____

Duration: date of onset: ___ days, ___ weeks, ___ months, ___ years, continuous since onset addt'l notes_____

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

Context: cannot identify, fall, bending, lifting, twisting, sports injury, work injury, MVA, assault, overuse, atraumatic, laceration addt'l notes_____

Alleviating Factors: nothing helps, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractic care, OTC medication, narcotics, NSAIDs, cortisone injection, viscosupplement injection, orthotics, previous surgery, brace, splint, sling addt'l notes_____

Aggravating Factors: cannot identify, lifting, carrying, twisting, pushing/pulling, gripping, grasping, squeezing, throwing, ROM, weight-bearing, exercise, previous surgery, computer use, changing clothes, getting out of bed, going from sit to stand, morning, daytime, nighttime, cold weather, damp weather addt'l notes_____

Associated Symptoms: weakness, numbness, tingling, swelling, redness, warmth, ecchymosis, catching/locking, popping/clicking, buckling, grinding, instability, radiating to thumb/index/middle, radiating to fourth/fifth, radiating to dorsal hand/thumb, radiating

proximally, drainage, fever, chills, weight loss, change in bowel/bladder habits addt'l notes_____

Previous Surgery: none, surgical procedure:_____ date:_____ addt'l notes_____

Prior Imaging: none, no recent studies, x-ray, MRI, CT scan, bone scan, EMG addt'l notes_____

Previous Injections: none, did not help, helped a little, helped temporarily, helped significantly addt'l notes_____

Previous PT: none, did not help, helped a little, helped temporarily, helped significantly addt'l notes_____

Work Related: no, yes addt'l notes_____

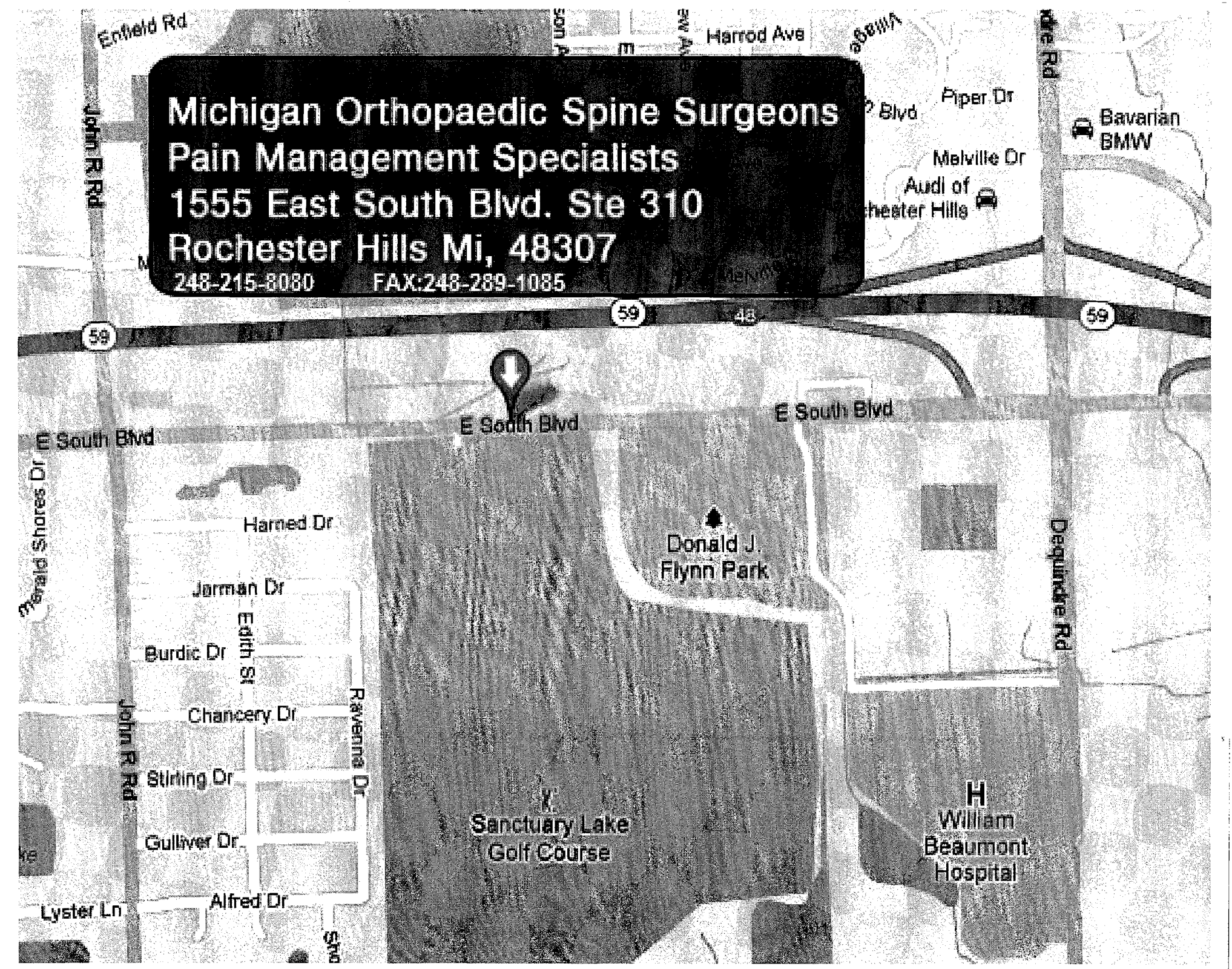
Working: no, regular duty, modified duty addt'l notes_____

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)


Michigan Orthopaedic Spine Surgeons
Pain Management Specialists
1555 East South Blvd. Ste 310
Rochester Hills Mi, 48307
248-215-8080 FAX:248-289-1085
Enfield Rd
Harrod Ave
John R Rd
Piper Dr
Melville Dr
Bavarian BMW
Audi of
59
E South Blvd
Harned Dr
Donald J. Flynn Park
Jarman Dr
Burdic Dr
Edith St
Chancery Dr
Ravenna Dr
Stirling Dr
Gulliver Dr
Alfred Dr
Lyster Ln
Sanctuary Lake Golf Course
William Beaumont Hospital
Dequindre Rd