Orthopedic Institute of Michigan, PLLC

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Dear Patient:

The Orthopedic Institute of Michigan, PLLC would like to welcome you to our office. Enclosed you will find a number of forms. Please fill them out completely and bring them with you to your appointment, email them to oimmain@gmail.com or mail them back to us. Due to the new healthcare regulation we may be unable to see you without this information.

If you have health insurance, please bring your insurance cards and photo identification so that we can make a copy of them for our records. If you are a tele-health appointment please email a copy of your insurance card(s) and ID to oimmain@gmail.com . This is necessary so that we may properly file our claims with you insurance company.

We recommend that you call your insurance company to confirm that we are in your health network and to see if it is necessary to obtain a referral to see our physicians. This could save you a lot of time and money, if you confirm this before the appointment. **It is your responsibility to provide this office with any insurance referral(s) necessary to obtain medical care from the Orthopedic Institute of Michigan. You may not be seen if you insurance referral is not received by your appointment date**.

Please bring or email a list of your current medications. If you have any questions regarding your appointment, please feel free to contact the office. We look forward to seeing you on _____ at _____.

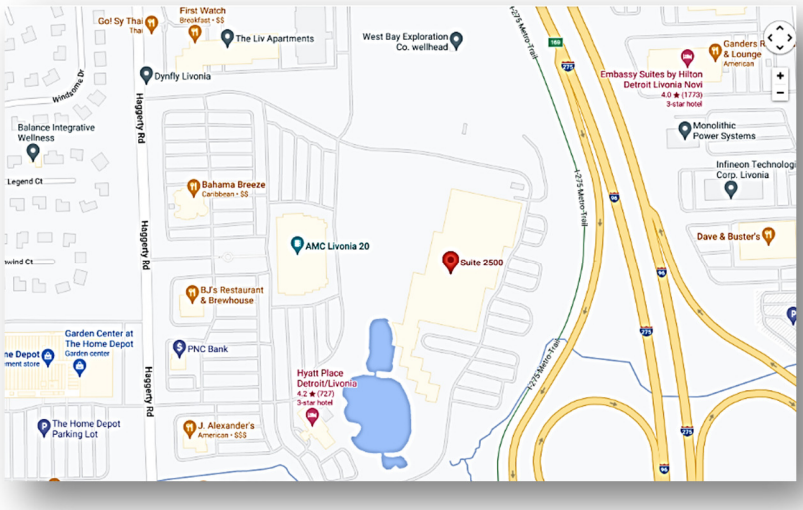
Sincerely,

Orthopedic Institute of Michigan

Located at: 39000 W Seven Mile Rd, Suite 2500
Livonia, MI 48152
Off of Seven Mile, East of Haggerty

Tele-health Link:

https://oim.doxy.me/



ORTHOPEDIC INSTITUTE OF MICHIGAN **ACCOUNT#_____**

Patient Name: _____ Date Of Birth: _____ Age: _____ Male/Female

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

SS#:_____ Phone #:_____ Home Or Cell (Circle One)

Patient Employer: _____ Work Phone #:_____

Emergency Contact: _____ Relationship: _____ Phone #:_____

Married Single Widowed Divorced (Circle One) Email:_____

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name (If Not Self): _____ Subscriber Date Of Birth:_____

Subscriber SS#:_____ Relationship: _____

HAVE YOU OR ARE YOU CURRENTLY LIVING IN A SKILLED NURSING FACILITY: Yes Or No
Date of Admission: _____ Date of Discharge: _____

Primary Care Physician:_____Phone #:_____

Did Your Family Physician Refer You Here: Yes Or No

If Not, How Did You Hear About Our Facility: _____
Pharmacy Name:_____ Phone #:_____ Crossroads: _____

IF YOUR INJURY IS WORKMAN'S COMPENSATION, AUTO ACCIDENT, OR PUBLIC LIABILITY – AUTHORIZATION IS REQUIRED BEFORE YOU CAN BE SEEN IN OUR OFFICE

Is This Injury Do To An Auto Accident: Yes Or No _____ **(PLEASE INITIAL)**

Is This Injury Work Related: Yes Or No _____ **(PLEASE INITIAL)**

Is This Injury Liability Related: Yes Or No _____ **(PLEASE INITIAL)**

REASON FOR TODAY'S VISIT:

SINGLE** Area Of Body Being Examined: _____ Lt Rt

Date Of Injury Or Onset Of Symptoms: _____

Where & How Did Your Injury Occur:_____

Have You Been Treated For This Before: Yes Or No

Were You Seen In An Emergency Facility: Yes Or No

If Yes, Where & Date: _____

Would you like a Chaperoned Office Visit? Yes or No Male or Female

******One body part per visit, please

37669 Pembroke Ave Livonia, MI 48152 Phone: 734-464-0400 Fax: 734-464-0404
www.orthomich.com

Orthopedic Institute of Michigan, PLLC

Financial and Privacy Notification

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans. (e.g. services rendered by health care providers who do not participate with my insurance plan.) All copays and office visit balances are due on the day of service. If you policy is Blue Cross Traditional or Master medical the office visit charge is due on the day of service, for Master Medical policies, as a courtesy, we will submit your claim to Blue Cross upon receipt of your payment to us. If you are an HMO patient, it is your responsibility to obtain a referral from you Primary Care Doctor; if we do not have you referral your appointment will be rescheduled. Please call 24 hours before your appointment to see if your referral is here or still valid from your last visit. It is your responsibility to know your insurance policies and coverage. Failing to do so will result in you being responsible for all costs incurred. Please remember your insurance policy is between you and your company and not with the insurance company and your doctor. If the insurance company does not make payment within 45 days, you will assume immediate responsibility for the payment and deal with the insurance directly. By signing below, you hereby authorize your insurance benefits to be paid directly to the above physicians, realizing that you are responsible to pay non-covered services, and you hereby authorize the release of pertinent information to the insurance carriers. I understand my right to request the presence of a chaperone during my visit. The chaperone may be a patient advocate or a staff member. Our staff will maintain patient confidentially standards set by the Orthopedic Institute of Michigan. When a chaperone is present, the provider will try to keep all questions of a sensitive nature to a minimum.

_____

Patient's signature

To our patients with Medicare Insurance

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopedic Institute of Michigan, PLLC for any services furnished me by their physicians. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Patient's signature

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have been given the choice of receiving a copy of the Privacy Practice.

I have **Accepted** or **Refused** (Circle One) Orthopedic Institute of Michigan's Policy.

_____

Patient's signature

_____ _____

Witness of Signatures (office use only) **Date signed**

Patient Medical History Questionnaire

Name _____ **Male** _____ **Female** _____ **Age** _____

Height _____ **Weight** _____ **BMI** _____ **Telephone Number** _____

Primary Doctor _____ **Telephone Number** _____

To your knowledge, do you now have or have you ever had any of the following:

YES	NO		YES	NO	
_____	_____	Arthritis	_____	_____	High Blood Pressure
_____	_____	Asthma	_____	_____	Kidney Disease
_____	_____	Bleeding Tendencies	_____	_____	Liver/Disease/Hepatitis
_____	_____	Bleeding or Bruising	_____	_____	Lung Disease/Emphysema
_____	_____	Blood Transfusion(s)	_____	_____	Stomach Ulcer
_____	_____	AIDS/HIV positive	_____	_____	Stroke
_____	_____	Cancer (If yes what type) _____	_____	_____	Thyroid Disease
_____	_____	Diabetes	_____	_____	Tuberculosis
_____	_____	Phlebitis	_____	_____	Hearing or Vision Problems
_____	_____	Heart Disease/Failure	_____	_____	Nose or Throat Problems
_____	_____	Heart Murmur	_____	_____	Epilepsy/Seizures
_____	_____	Mitral Valve Prolapse	_____	_____	Do you use street drugs?
_____	_____	Do you drink Alcohol?	_____	_____	Do you smoke?

(If so how much & how often) _____ (If yes how many packs per day) _____

_____ _____ Have you been treated for depression (in the last 3-6 months)

_____ _____ Have you had you flu shot (if so when) _____

_____ _____ Have you had a bone density test (if so when) _____

_____ _____ Have you received a pneumococcal vaccine (if so when) _____

_____ _____ Pain Level on a scale from 0 to 10 being the worst what would you rate your pain _____

_____ _____ Could you be pregnant? (For the area of the body being examined today)

_____ _____ Advanced care plan

List all allergies (drugs, latex, tape, food): _____

List all medications (include non-prescription herbal supplements/patches/nutritional supplements):

_____

_____

List previous operations: _____

_____

Have you ever had complications from anesthesia preoperatively or postoperatively? **Yes** _____ No _____

If yes please explain: _____

I hereby certify that all statements and answers provided by me in this examination for is true to the best of my knowledge.

Name _____ **Date** _____

Dear Patients,

It is the policy at Orthopedic Institute of Michigan to only refill prescriptions at the following times:

MONDAY THROUGH THURSDAY FROM 8:30AM TO 4:00PM

FRIDAY 8:30AM TO 12:00 NOON

Please notify the office **72** hours before you are out of the medication(s) to allow for time to speak with the physician.

Prescriptions will **not** be called in on the weekend

All HMO's requiring a referral must have a current referral for each and every appointment or the fees for the appointment will be the patient's responsibility **ON THE DAY OF SERVICE. IT IS THE PATIENT'S RESPONSIBILITY TO ACQUIRE A REFERRAL FROM HIS/HER PRIMARY CARE PHYSICIAN**.

All other medical plans, the patient MUST pay all fees on the day of service.

Sincerely,

Orthopedic Institute of Michigan

I have read and understand the policies as stated above

_____ _____

Patient Signature Date