

Dear Patient,

We would like to take this opportunity to welcome you to Southwest Michigan Center for Orthopaedics and Sports Medicine. This packet of information is being sent to you to complete and bring in with you. You may keep the enclosed financial policy/HIPPA policy for your records.

Please take a moment and review the following:

-Please **bring along** any medications you may be taking or bring in a detailed list.

-If you have had any recent MRI's or X-rays please **bring them**, along with any reports that go with these films. (Please do not arrange to have films sent as they sometimes are not received in time for appointment.)

- Please **bring along** your insurance cards and photo id.
All co-pays are expected at check in (please be aware of your co-pay amount)

- Please read the enclosed financial policy to assist you with the information we require. Without the needed information we may need to reschedule your appointment.

*If you are being seen under Workman's Compensation (work injury) please call our office 24 hours prior to appointment to verify we have received your authorization. You may call (269) 428-3500.
Your appointment may need to be rescheduled if the appropriate information is not received.

**Southwest Michigan Center For Orthopaedics and Sports Medicine
183 Peace Boulevard
Saint Joseph, Mi 49085
Phone (269) 428-3500 Fax (269) 429-6429**

**We are located Southeast from the corner of Maiden Lane and
Hollywood Rd
(Across the street from The Center for Outpatient Services)**

www.swmortho.com

**SW MI CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE
PATIENT INFORMATION FORM**

Patients Last Name _____ First _____ M.I _____ Prefer to be called _____

Address _____ City _____ State ____ Zip _____

Date of Birth _____ Age _____ Social Security # _____ / _____ / _____ Sex M F

Home Phone () _____ Cell Phone () _____

Employment Status(please circle) FULL PART MILITARY RETIRED STUDENT Marital Status S M D W

Employer's Name _____ Work Phone () _____

Primary Care Physician _____ Referring Physician _____

~~~~~  
**Responsible Person (if patient is under 18)**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different from patients) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Marital Status S M D W Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

~~~~~  
Emergency Contact Person (**OUTSIDE OF HOUSEHOLD**) _____

Relationship _____ Phone () _____

Do we have permission to leave a message at the numbers you've listed YES NO

~~~~~  
Date of Injury \_\_\_\_\_ or Onset Date \_\_\_\_\_

**\* DID THIS INJURY/MEDICAL PROBLEM OCCUR AT WORK? YES NO**

**\* If you have answered yes, we must have a written authorization for treatment from your employer.**

~~~~~  
DO YOU HAVE MEDICAL INSURANCE YES NO (if yes please answer the following)

_____ \$ _____
PRIMARY INSURANCE NAME Contract Number Group # **CO-PAY AMOUNT (if Applicable)**

_____ / _____ / _____
NAME OF SUBSCRIBER IF DIFFERENT FROM PATIENT Date of Birth Social Security #

_____ _____
SECONDARY INSURANCE NAME Contract Number Group #

_____ / _____ / _____
NAME OF SUBSCRIBER IF DIFFERENT FROM PATIENT Date of Birth Social Security #

Your signature below signifies that you have read and understand our financial policy and HIPPA
(Protected health information) policy. Further it acknowledges your responsibility regarding charges related to your care.

Patient's signature (if 18 or older)

Date

Parent/Guardian's signature (if patient is a minor)

Date

SOUTHWEST MICHIGAN CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

Medical History Form

DATE: _____

Patient Name _____ **Date of Birth** _____

Age _____ Who is your family physician? _____

Who referred you to our Office? _____

Present Orthopedic Problem: _____

Date of injury/onset: _____ Did injury occur at work? **Yes** **No**

Have you had problems like this before? _____ When? _____

Please describe how the injury happened: _____

Have you seen any other physicians for this problem? **Yes** **No**

Who did you see? _____, if so were any test or treatments done? **Yes** **No**

What has been done? (X-rays, MRI, EMG, etc.) _____

Do you have any **Allergies** or reactions to medications? **YES** **NO**

If so, which medications? _____

Reactions: _____

Please List **all** current medications you are now taking: None

Medication **Dosage** **Frequency**

Medication	Dosage	Frequency

May use back of page to list other medications if more space is needed.

See back for more medications **yes** **no**

SURGERY HISTORY

Have you had any of the following surgeries? If so when?

Angioplasty/Angiogram **Y N** _____ **Bone/Joint** **Y N** _____

Open Heart Surgery **Y N** _____ **Prostate** **Y N** _____

Carotid Surgery **Y N** _____ **Hysterectomy** **Y N** _____

Gall Bladder **Y N** _____ **Thyroid** **Y N** _____

Breast Surgery **Y N** _____ **Hernia** **Y N** _____

Vascular Surgery **Y N** _____ **Back** **Y N** _____

Appendectomy **Y N** _____ **Nasal** **Y N** _____

Tonsillectomy **Y N** _____ **Vasectomy** **Y N** _____

Neuro Surgery **Y N** _____

Please List any other surgeries you have had: _____

If you have had Bone/Joint Surgery please explain in detail: _____

Have you ever had any complications with an anesthetic during surgery? Yes No

If Yes Please Explain _____

MEDICAL HISTORY

How would you describe your health in general? Excellent Good Fair Poor

Are you currently having or have had problems with any of the following:

(Describe all Yes answers and approximate date)

- | | | | |
|------------------------|-----------------------------|------------------------------|-------|
| Eyes | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Thyroid Disease | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Ear, Nose, Throat | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Lungs, Breathing | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Chronic Cough | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Heart Failure | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Heart Attack | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Palpitations | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Digestion | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Ulcers | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Hiatal Hernia | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Hepatitis | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Liver Disease | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Kidney Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Urinary Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Painful Urination | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Bowel Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Blood in Stool | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Diabetes | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Stroke | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| High Blood Pressure | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Bleeding Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Balance Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Anemia | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Numbness/Tingling | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Headaches | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Blackout/fainting | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Psychological Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Depression | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Cancer/Type of | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Arthritis | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Rheumatoid Arthritis | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Polio | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| HIV | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| High Cholesterol | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| TB | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Epilepsy/Seizures | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Fractures/Broken Bones | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |
| Skin Problems | NO <input type="checkbox"/> | YES <input type="checkbox"/> | _____ |

SOCIAL HISTORY

Do you smoke? **Yes** **No** How many packs per day? _____

How long have you smoked? _____

Do you drink alcoholic beverages? **Yes** **No** How many drinks per day? _____

How Many drinks per week? _____

Do you use recreational drugs? **Yes** **No** What kind ? _____

How often? _____

Marital Status: Married Single Divorced Widowed Separated

Occupation: _____

Where are you employed? _____

Family History

Have any direct relatives had any of the following disorders? If so, which relative

Diabetes Yes No

High Blood Pressure Yes No

Heart Disease Yes No

Rheumatoid Arthritis Yes No

None of the above _____

Do any direct relatives have the same condition you are being seen for today?

Yes No

Signature _____ Date _____

Form reviewed by: _____

Date: _____

SOUTHWEST MICHIGAN CENTER FOR ORTHOPAEDICS
& SPORTS MEDICINE

FINANCIAL POLICY

PLEASE KEEP THIS FOR YOUR RECORDS

Thank you for choosing Southwest Michigan Center for Orthopaedics & Sports Medicine for your orthopaedic care. We are committed to providing the best care possible. The following document explains our financial policy, which we ask you to review at this time and sign.

INSURANCE

Orthopaedic surgery is a specialty practice and your insurance carrier may require that you obtain a referral from your primary care provider before being seen. As the insured member, this is **your** responsibility. We recommend that you contact your health insurance carrier to determine whether you need a referral before scheduling an appointment. Our practice participates in most local insurance plans and we can provide you with the list of insurance companies that we do participate with. Ultimately, however, it is **your** responsibility to determine whether or not we are a participating provider for your insurance carrier. You must provide your insurance card at every visit and we ask that you tell us of any changes to your address, phone number, employment status, or insurance coverage. We will also ask for a copy of your driver's license as this is standard protocol for medical practices in Michigan. If you do not have the information requested, i.e. insurance cards or driver's license, we may ask you to reschedule your appointment.

CO-PAYS, DEDUCTIBLES, AND NON-COVERED SERVICES

All co-payments, deductibles and non-covered services are due at the time of service. We cannot waive co-pays or deductibles, as this would be a breach of contract between you and your insurance carrier. It is your responsibility to know your provisions for co pays and deductibles as this is a contract between you and your insurance carrier. Our practice will not become involved in disputes between you and your insurance carrier. All services may not be considered a covered service by your insurance company. This then makes you financially responsible for these services. It is necessary that you understand your healthcare is not dictated by your health insurance carrier, but by what the physician feels necessary to provide you the best care. If we schedule an elective surgery for you, we will be checking with your insurance company. If it is found that deductibles have not been satisfied or that co-pays will be owed, full payment of these fees will be required prior to the surgery date.

CLAIM SUBMISSION

We will submit claims to all insurance companies in which we are participating providers. Our staff will be more than willing to help you in submitting claims to insurance companies that we do not participate with. Your insurance carrier may require you to supply certain information directly to them. It is **your** responsibility to comply with their request.

WORK/AUTO INJURIES

(Workman's Compensation)

If you have experienced a work or auto accident related problem you will be required to provide the necessary information for your appointment.

For **Work related** injuries you must obtain a written authorization from your employer before your visit. The authorization is to be faxed into our office prior to your appointment. The authorization **MUST** include the following information: claim number, insurance carrier name and address, date of accident, and employer information. We cannot see you under a workman's compensation claim if this information is not present at the time of visit. Also, we can not bill your regular insurance for an injury that occurred at work. Please call our office 24hrs prior to your appointment to verify the authorization has been received.

You may have the authorization faxed to ATTN APPOINTMENTS @ 269-429-6429

For an **Auto claim** you will need to provide us with the billing address of your Auto insurance along with the policy/contract number. Please bring this information in for your appointment.

NON-PAYMENT

If your account becomes 60 days past due, you will receive a letter reminding you that you must satisfy this debt and pay the account in full within 15 days. Please be aware that if a balance remains unpaid we will then refer your account to a collection agency. Your medical care is a valued service and your compliance with the financial responsibilities of this service is appreciated. Please understand that our financial staff is happy to work with you. Also, understand that a lack of insurance coverage or underinsurance does not remove your responsibility for the full payment at the time of service.

RETURNED CHECK

In the event that we receive a returned check due to insufficient funds, a \$30 fee will be charged to your account and payment is due upon receipt of your statement.

INSURANCE FORMS, MEDICAL RECORDS, AND DISABILITY FORMS

We charge a fee for completing insurance forms, copying medical records, and disability verification forms. These activities are extremely time consuming for our staff and cannot be expected to be performed free of charge. Also, be aware that these services require seven to ten business days to complete.

FORMS OF PAYMENT

For your convenience, we accept cash, check, MasterCard and Visa. We also participate in the Care Credit Program, which is a creative way of providing low cost financing for medical care. Our billing representative will be more than happy to explain these services to you. Please do not hesitate to ask if you have any questions. Often bill disputes are the result of miscommunication and our financial personnel pride themselves on excellent customer service and their ability to help our patients deal with the often difficult financial circumstances that illness and injury present.

**Southwest Michigan Center for Orthopaedics and Sports Medicine
GENERAL CONSENT FORM to the USE and DISCLOSURE of PROTECTED
HEALTH INFORMATION**

I understand that **Southwest Michigan Center for Orthopaedics and Sports Medicine** creates and maintains medical and related records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care treatment. This is my “protected health information.”

I understand and consent to the use and disclosure of my Health Information by **Southwest Michigan Center for Orthopaedics and Sports Medicine** for the following purposes:

* My Treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.

* Payment for healthcare services provided to me: This include actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.

* My Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

I understand and agree that:

* I have the right to review **Southwest Michigan Center for Orthopaedics and Sports Medicine's** *Notice of Privacy Practices for Protected Health Information*, which provides a much more detailed description of information uses and disclosures, prior to signing this consent.

* **Southwest Michigan Center for Orthopaedics and Sports Medicine** may change or modify its *Notice of Privacy Practices for Protected Health Information* at any time and I have the right to obtain a revised notice or privacy practices by accessing the **Southwest Michigan Center for Orthopaedics and Sports Medicine's** website, calling the office and requesting a revised copy sent in the mail or asking for one at the time of my next appointment.

*I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.

* I have the right to revoke this Consent by notifying my Provider **in writing** that I revoke this Consent unless my Provider has used or disclosed my Health Information in reliance on this Consent.

*My Provider has the right to disclose relevant Health Information to my family member, other relative, close personal friend, or anyone identified by me.