ORTHOPEDIC SURGERY OF MACOMB

Ronald Meisel, DO   Robert Carson, DO

16570 19 Mile Rd   Clinton Township, MI 48038   (586) 226-7400

As the healthcare insurance industry increasingly drives the development of the "managed care" environment for both patients and doctors, it can easily become an *overwhelming process* for a patient to complete all the insurance forms. To help you determine what information and actions will be required on your part, we want to highlight some of the office policies. Also so you know what to expect from our office and what is expected from you, as a patient. To ensure time for a concise evaluation, Dr. Meisel and Dr Carson will only see patients for one body part at a time. If you should have any additional questions, please ask our Front Desk or Billing Staff. We want you experience with our office to be as smooth as possible.

OFFICE VISIT CO-PAYMENTS / DEDUCTIBLES / MASTER MEDICAL AND ALL NON-COVERED SERVICES: Payment is required for your co-payments / Deductibles / Master Medical and Non-covered services at the time of service, unless arrangements have been previously arranged with our Office Manager prior to your appointment. ***We accept Cash, Debit, Personal Checks (processed thru Telecheck), Visa**, **MasterCard, Discover and American Express.***

INSURANCE CARDS / PICTURE ID: You are responsible to **supply our office with all current insurance cards at time of appointment**. If you do not have this information, then the account will become **SELF-PAY**. You will be responsible for the entire visit. If this is not acceptable to you, we will need to reschedule your appointment until you are able to supply the proper cards.

CANCELLATION POLICY: If you should need to cancel or reschedule your appointment we ask you do so **at least 24 hours in advance**. As we have a system that calls you 48 hours prior to your appointment with a reminder. This will allow us to accommodate another patient. If less than a 24 hour notice is given there is a **Cancellation Fee of $35** will be applied to your account.

HMO / MANAGED CARE / PARTICIPATING PROGRAMS: **You are responsible for obtaining any necessary referrals or authorizations your plan may require before each visit. You are responsible for paying co-pays or deductibles at the time of the visit** As per **your** agreement with your carrier, if you fail to take these following steps **you will be responsible for the entire payment**. If all steps are followed, we will submit all charges and follow-up with your carrier for payment.

AUTO / WORKERS COMPENSATION: You will need to **obtain an Open Claim Letter from your carrier** with the pertinent billing and claim information. **Without this information at time of appointment your appointment will need to be rescheduled.** As many Some No Fault Carriers have deductible on medical charges for which the patient is responsible.

PHYSICIAN REFERRALS: *I*f you are being sent to our office by another Physician for Dr. Meisel's or Dr. Carson's opinion – **you are responsible to obtain a referral letter from that physician prior to your office visit indicating the reason for the visit.**

INSURANCE FORMS / FLMA / DISABILITY: We will fill out forms that are brought into the office for a **nominal charge** ($10 to $15.00). Due to the busy office schedule **we require 5-7 business days to complete these forms**. The charge must be made before any completed forms are released.

PAYMENT ARRANGEMENTS: We gladly accept **CASH, Debit, Personal Checks, VISA, MasterCard, Discover and American Express**. Should you need to make payment arrangements, please feel free to contact our Office Manager to make such arrangements. We know that times are tight, and you may need to take several months to satisfy you balance. We ask that if you have to carry your balance – that small monthly good faith payment be made.

PATIENT / OFFICE AGREEMENTS: I , ________________________________, give Orthopedic Surgery of Macomb permission to:
(check all that apply)
___ Allow to call my home about appointments
___ Allow to leave messages on my answering machine at (______) _________________.
___ Allow to call my work place, if necessary at (______) _________________________.
___ Allow to leave messages at my e-mail address at ____.
___ Allow to leave messages concerning appointments with: __________________________________ Relationship: _________________
___ Allow to discuss my medical condition with: ____

I, ____ have read the above Office / Financial Policy, and agree to follow the Guidelines as indicated. Orthopedic Surgery of Macomb, PLC / Ronald Meisel, DO / Robert Carson, DO as a courtesy will bill the services directly to your insurance carrier(s). Per the dictates of your carrier, you will be responsible for the balances they have applied, or non-covered services.

Signature:____ Date: _______________________________________

(Patient or Guardian)

ORTHOPEDIC SURGERY OF MACOMB, PLC
RONALD L MEISEL D.O. ~ ROBERT F CARSON D.O.

Patient Information Sheet

Patient Last Name:______________________________________ First Name:_____________________ Middle Init:____________

Street Address:____City:_____________________ State:______Zip:__________

Primary Phone: (____)__________________ Social Security Number: ____________________ Height:______ Weight:________ Work:

(____)________________ Cell:(_____)_________________ Birth Date:___________________ Age:______ Sex:_______

Martial Status S M W D Employer:______________________________Job Description:__________________________

Emergency Contact: ___________________________________ Relationship _______________ Phone #: (_____) _____________

Who referred you to our office? ____

Family Physician Name: ____ Phone #: (______)________________

Address: ____ City: ________________________________ Zip: ____________

Insurance Information

Insurance Carrier Name: ***Primary***:____

Subscriber's Last Name:________________________________ First Name:______________________ Birth Date:_____________

Subscriber SS#: :___________________ Employer's Name:_________________________________Phone #:(____)_____________

Employer's Address: ____

Insurance Carrier Name: ***Secondary***: ____

Subscriber's Last Name:________________________________ First Name:_______________________ Birth Date:____________

Subscriber SS#: :___________________ Employer's Name:________________________________ Phone #:(____)______________

I hereby authorize payment directly to Ronald Meisel, D.O. or Robert Carson, D.O. of the surgical and/or medical benefits payable to me for the services as described but not to exceed the reasonable and customary charges for those services. I authorize any holder of medical or other information about me to release such information that is necessary to process these claims or related medical claims. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible to the doctor for the charges not covered and any late fees applied to the account.

Signature____ Date_________________________________

Current problem for this evaluation

What is the main reason for your visit? _____ Pain ____ Numbness ____ Weakness ____ Swelling ____ Stiffness

What body part is involved? ____Right ___________ Left ___________

When did condition begin? Date ____

Are you: Right Handed _____________ or Left Handed _________________

Is your problem **WORK RELATED**? YES NO Date of Injury__________________ Adjuster Name:______________________________
Phone #: (_____)______________________________

Is your problem **AUTO RELATED**? YES NO Date of Injury __________________ Adjuster Name:______________________________
Phone #: (_____)______________________________

Is your problem **SLIP & FALL**? YES NO Date of Injury __________________ Adjuster Name:_______________________________
Phone #: (_____)______________________________

Have you had this problem before? _______ NO _______ YES   If YES, When: ____

Your Current Work Status: _____ Regular _____ Light Duty (how long? ______) _____ Not Working (due to this problem)

_____ Disabled _____ Retired _____ Student

If you are not working, when is the last date you worked at your regular job? ____

On a scale of 1-10 (10 is the worst), how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 (circle)

What is the quality of the pain? ____ sharp ____ dull ____stabbing ____ throbbing ____aching ____burning

The pain is: _____ constant ______ comes and goes   Does your pain wake you from sleep? ____YES ____ NO

What makes your symptoms better? _____ rest _____elevation _____ ice _____ heat ____ other ______

What tests have you had for this problem? ____________ XRAY________MRI_____CT Scan _____ Bone Scan _____ EMG

Are you currently receiving or do you plan to apply for:

Disability _____ YES _____ NO   Workers Compensation _____ YES _____ NO   Unemployment _____ YES _____ NO

Has an Attorney been consulted? YES NO   Name of ATTORNEY____Phone# _____________

Your Medical History *(Check all that apply)*

______ Thyroid Disease
______ Heart Disease
______ High Blood Pressure
______ Angina/Chest Pain
______ Heart Attack

______ Asthma
______ COPD/Emphysema
______ Diabetes

_________Kidney Disease
_________Liver Disease
_________ Ulcers
_________ Stroke
_________ Seizures

__________ Tuberculosis
__________ Anemia
__________Substance Abuse

_______ Cancer : ___________________
________ Acid Reflux
________ Bleeding/Clotting Problems
________ Blindness/Vision Difficulty
________ High Cholesterol

________ Prior Blood Transfusion
________ Mental Disorder
________ Other: _____________

Your Surgical History (List all Surgeries and dates if known)____

____

____

Your Family History ______ Heart Disease ______ Diabetes ______ Cancer ______ High Blood Pressure ______ Arthritis

Your Social History

Smoker: ______ NO ______ YES ______packs/day _______ quit smoking _______ (years)

Alcohol: ______ None ______ Occasional _______ Frequent ________ times a week

Do **you** currently experience any of the following? (Check all that apply)   If none apply, check here ______________

General:	______ Weight Loss	_______ Fevers	_______ Fatigue
Cardiovascular:	______ Chest Pain	_______ Irregular Rhythm	_______ Heart Murmur
Gastro Intestinal:	______ Heartburn	_______ Stomach Ulcers	_______ Hepatitis
Musculoskeletal:	______ Arthritis	_______ Osteoporosis	_______ Prior Fracture
Neurological:	______ Dizziness	_______ Weakness	_______ Headaches
Respiratory:	______ Sleep Apnea	_______ Shortness of Breath	_______ Wheezing
Urinary:	______ Painful Urination	_______ Urinary Infection	_______ Frequency
Endocrine:	______ Diabetes	_______ Thyroid Problems	_______ Hypoglycemia
Hematology:	______ Blood Clots	_______ Bleeding Problems	_______ Phlebitis
Immunologic:	______ Tuberculosis	_______ HIV	_______ AIDS Infection
Psychiatric:	______ Depression	_______ Anxiety	_______ Sleeplessness
Eyes:	______ Need Glasses	_______ Glaucoma	_______ Dry Eyes
Ears/Nose/Throat:	______ Hearing Loss	_______ Sinus Infections	_______ Chronic Cough
Skin:	______ Rash / Sores	_______ Psoriasis	_______ Easily Bruise

List **ALL** **Medications** you are taking : (also include non-prescription) ____

____

____

____

Do you have any **Medication Allergies**? ______ NO ______ YES ____

Are you on **Blood Thinners**? _______ YES _______ NO

Certificate of Authenticity

I hereby certify that ALL the above history information is true and correct to the best of my ability.

Signature: ____ Date: ___________________________

(Patient or Guardian)

HIPAA Notice of Privacy Practices

Ronald Meisel D.O. ~ Robert Carson, D.O.
16570 19 Mile Road
Clinton Township, MI 48038
(586) 226-7400

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Practice Policy on Patient Sign-In Sheets

The practice maintains patient sign-in sheets for verification of arrival that are visible and accessible to patients, staff and others who may enter this office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

SIGNATURE BELOW IS ONLY ACKNOWLEGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

PRINT NAME:__________________________SIGNATURE:____ DATE: __________________

Ronald L Meisel, D.O. / Robert Carson, D.O. / Orthopedic Surgery Of Macomb, PLC
Consent for the use and disclosure of protected health information

Patient Name____

I authorize this provider to release to any third party payer, or its representative, which may be responsible for payment in my case.

Signature: ____
(Patient or Legal Representative)

Receipt of Notice of Privacy Practices

By signing below I acknowledge that I have reviewed and /or received a copy of this office's Notice Privacy Practices.

Signature:____
(Patient or Legal Representative)

Financial Responsibility

I understand than I am financially responsible to pay deductibles, co-insurances or any other balance not paid by my insurance.

Signature:____
(Patient or Legal Representative)

MEDICARE PATIENTS

Assignment of Benefits: Medicare Patients
I request that payment of authorized Medicare and Medigap benefits be made on my behalf to this provider for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider listed above. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Medicare ID#____

Name of Medigap/Supplemental Carrier: ________________________________

Signature:____
(Patient or Legal Representative)