

16570 19 Mile Rd
Clinton Township,
MI 48038

ORTHOPEDIC SURGERY OF MACOMB
RONALD MEISEL, D.O.

ROBERT CARSON, D.O.

P: 586-226-7400
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Patient Name: _____ Date of Birth: _____ Gender: Male or Female

Address: _____ City/State/Zip: _____

Primary #: Cell or Home _____ Work #: _____ Marital Status: S / M / W / D (circle)

Email: _____ Occupation: _____ FT/ PT/Retired/Disabled/Student

Emergency Contact: _____ Phone: _____ Relation: _____

Family Physician Name: _____ Office Phone #: _____

Did your Family Physician refer you to us? Yes No (circle) If no, please indicate who referred you: _____

Present Complaint: _____ Right / Left / Bilateral (circle one)

When did your condition start? ____/____/____ How did your condition begin? _____

Have you had any xray/MRI/CT for this problem? Y / N When/where? _____

Hand Dominance: Right / Left Height: _____ Weight: _____

Social History: Do you consume alcoholic beverages? Y / N _____ quantity ☐ Daily ☐ Weekly ☐ Monthly

Smoking Cigarettes/Vaping currently? Y / N _____ packs for _____ years. Illicit Drug Use: Y / N

Previously smoked _____ packs per day for _____ years. Quit _____ years ago.

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis A/B/C	Y	N	Scoliosis	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Seizures	Y	N
Bladder/Prostate Problems	Y	N	Headache/Migraine	Y	N	Kidney Disorder Stage _____	Y	N	Stroke	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	High Blood Pressure	Y	N	Thyroid Disorder	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Ulcers	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Weakness/Paralysis	Y	N
Cholesterol	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Other:		

Family History: _____ Heart Disease _____ Diabetes _____ Cancer _____ High Blood Pressure _____ Arthritis

Current medications(including over the counter): _____

_____ ☐ Check if none

Allergies: _____

_____ ☐ Check if none

Past surgical history? ☐ No ☐ Yes If yes, please list: _____

I authorize Orthopedic Surgery of Macomb, PLC to release any medical information necessary to process my insurance claim and I authorize payment of medical benefits to be made to Orthopedic Surgery of Macomb, PLC for services rendered. I agree to pay my co-pays, deductibles and any balance that is denied or in dispute by my insurance company.

Signature: _____ Date: _____

Consent for the Use and Disclosure of Protected Health Information

Patient Name: _____ Today's Date: _____

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

Signature: _____
(Patient or Legal Representative)

Receipt of Notice of Privacy Practices (HIPAA)

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

Signature: _____
(Patient or Legal Representative)

Financial Responsibility

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

Signature: _____
(Patient or Legal Representative)

Assignment of Benefits: Medicare and Medigap Patients

I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Orthopedic Surgery of Macomb, PLC, 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 to Orthopedic Surgery of Macomb, PLC on my behalf. 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(if applicable): _____

Signature: _____
(Patient or Legal Representative)

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. 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 your 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, VISA, Mastercard, Discover and American Express.

Insurance Cards/Picture ID: You are responsible for **supplying our office with all current insurance cards at the 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 to 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 24-hour notice is given, there is a **Cancellation Fee of \$35** that 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 steps **you will be responsible for the entire payment.** If all steps are followed, we will submit all charges and follow-ups to your carrier for payment.

Auto/Worker's Compensation: You will need to obtain an **Open Claim Letter** from your carrier with the pertinent billing and claim information. Without this information at the time of your appointment, we will need to reschedule. No Fault Carriers may have deductibles on medical charges for which are the patient's responsibility.

Insurance Forms/FLMA/Disability: We will fill out forms that are brought into the office for a **nominal charge of \$25.** Due to the busy office schedule, we require 3-5 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 your balance. We ask that if you must carry your balance, that small, good faith payments be made.

Patient/Office Agreements: I, _____, give Orthopedic Surgery of Macomb, PLC, permission to: (Check all that apply)

- ☐ Allow to call my home about appointments.
☐ Allow to leave messages on my answering machine.
☐ Allow to call my workplace and leave a message if necessary.
☐ Allow to leave a message at my email address.
☐ Allow to leave messages or communicate about my appointments with: _____ Relation: _____
☐ Allow to discuss my medical condition with: _____

I, _____ have read the above Office/Financial Policy and agree to follow the guideline as indicated. Orthopedic Surgery of Macomb, PLC, Dr. Ronald Meisel and Dr. Robert Carson, 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 any non-covered services.

Signature: _____ Date: _____
(Parent or Guardian)