Michigan Spine And Brain Surgeons, PLLC
Patient Information

Patient's Name_____Age_____DOB_____

Mailing Address _____City _____ State _____ Zip _____

Street Address _____ ☐ Same as above

Phone (Home)_____ (Cell)_____ (Work)_____ **SSN** _____

Email: _____ *If you do not provide an email, you will not be able to access your medical information on your patient portal

Preferred Method of Contact: ☐ Email/Patient Portal ☐ Phone ☐ Text Message ☐ Mail
*If I refuse to participate in email/portal or text messages, the default will be communication by phone and mail.
These 2 options are necesarry me to remain under the care of Michigan Spine and Brain Surgeons, PLLC.

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Responsible Party_____ Relation to patient _____
(If other than patient)
Address_____Cell_____Phone_____

Have you ever filed an **Auto** or **Workers Compensation** claim? ☐ No ☐ Yes

If yes, please supply all the following information: ☐ Auto related accident ☐ Work related accident

Carrier name _____Claim # _____ Adjuster_____ Authorized by_____

Address_____Phone _____ Fax_____

Date of injury/accident _____Where did the accident/injury occur?_____

How did the accident/ injury happen?_____Last day worked_____

Facility first treated _____ Admit date _____Discharge date_____

Other responsible party_____

Attorney Name _____ Attorney Phone Number_____

In Litigation: Yes / No Attorney Address _____

Occupation_____Employer_____Phone_____

Address_____

Emergency Contact_____Relation_____Phone_____

PRIMARY INSURANCE Effective date/Auth. #_____

Carrier name_____List all numbers on card _____

Subscriber name_____DOB_____SSN_____ Relation to patient_____

SECONDARY INSURANCE Effective date/Auth. #_____

Carrier name_____ List all numbers on card _____

Subscriber name_____DOB_____SSN_____Relation to patient_____

Michigan Spine And Brain Surgeons, PLLC
Patient Information

REFERRING PHYSICIAN / IME FOR ATTORNEY OR INSURANCE (PLEASE CIRCLE ONE)

Name_____Phone_____Fax_____

Address_____

PRIMARY CARE PHYSICIAN

Name_____Phone_____Fax_____

Address_____

Michigan Spine & Brain Surgeons, PLLC.

We would like to thank you for taking the time to complete this short questionnaire. We apologize for any inconvenience. Electronic Health Records serve as an important facilitator for collecting patient demographic data. The 2009 economic stimulus bill and 2010 health system reform bills, both strongly encourage collection of this data. Due to recent government initiatives to promote the use of electronic health records and in compliance with Meaningful Use, the reporting of the patient's racial background is now a requirement. Please complete the following information regarding the patient who is being seen today.

If you are uncomfortable answering the questions, you may select "I decline to specify".

Race: □ White □ Black or African American □ Asian □ Asian Indian

□ American Indian □ Arab □ Decline to Specify □ Other Race: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify

Language (if not English): _____

_____ _____

Patient Initials (Guardian Initials if patient is a minor) Date

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
MEDICAL HISTORY

DATE:

Before your visit today, have you been to the following:

□ ER □ Urgent care facility □ Rehab facility □ A physician's office □ Hospital for surgery

If yes, please indicate the date of your visit and the reason:

Type of Facility and Date:	Reason for Visit:

Chief Complaint_____ When did the problem start _____

Explain what difficulties bring you to us?

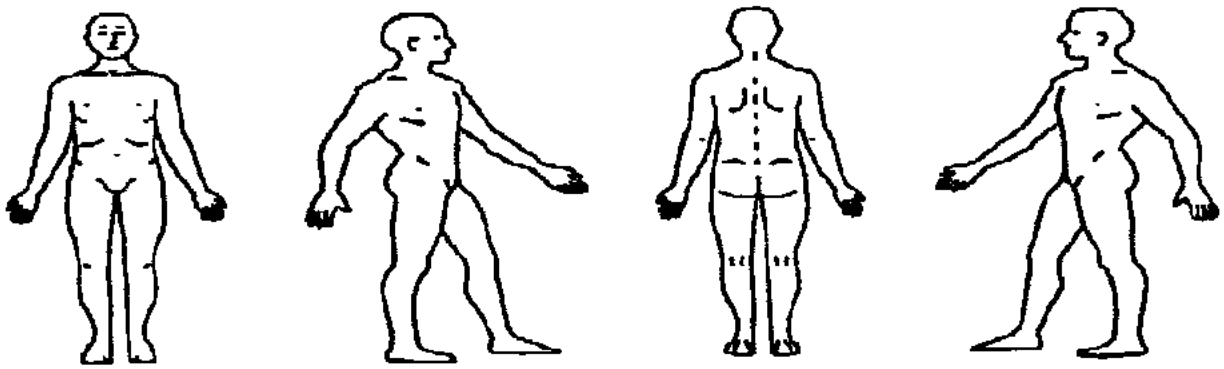
_____

_____

Percentage of pain in your body (0-100%), for example, BACK 60%, RIGHT LEG 30%, LEFT LEG 10%:
Shade the human below where your pain is and X where it hurts the most.

BACK _____ (%) **RIGHT LEG** _____ (%) **LEFT LEG** _____ (%) **Or check ☐ if you are**

NECK _____ (%) **RIGHT ARM** _____ (%) **LEFT ARM** _____ (%) **here for brain/other.**



If you were seen in the hospital, please state where the pain was and what the symptoms were: _____

Have you undergone CAT scan? ☐ Yes ☐ No Have you undergone EMG/nerve conduction study? ☐ Yes ☐No

Have you undergone MRI scan? ☐ Yes ☐ No Have you undergone X-Ray? ☐ Yes ☐ No

Have you undergone physical therapy? ☐ Yes ☐ No Have you undergone pain clinic treatment? ☐ Yes ☐ No

Are your symptoms improved? ☐Yes ☐ No, if yes, by how many percent? _____

Are your symptoms getting worse? ☐Yes ☐ No, if yes, by how many percent? _____

_____
Patient Initials (Guardian Initials if patient is a minor)

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
MEDICAL HISTORY

REVIEW OF SYSTEMS, **do you have:**

Constitutional: ☐ recent weight loss ☐ low energy level ☐ fever ☐ loss of appetite
Eyes: ☐ blurring of vision ☐ flying black spots ☐ loss of visual fields ☐ double vision
ENT: ☐ nasal discharge ☐ nose bleeding ☐ Ringing in the ears ☐ Trouble hearing ☐ Trouble swallowing
Cardiovascular: ☐ loss of consciousness ☐ Palpitation ☐ Angina ☐ Pedal edema
Respiratory: ☐ short of breath ☐ cough ☐ sputum ☐ wheezing
Gastrointestinal: ☐ nausea/vomiting ☐ reflux ☐ ulcer ☐ bloody diarrhea ☐ constipation ☐ jaundice
Genitourinary: ☐ painful urination ☐ hesitancy ☐ poor stream ☐ failure to eject ☐ failure to erect
Reproductive: ☐ Normal ☐ abnormal **Sexual function:** ☐ Normal ☐ abnormal
Musculoskeletal: ☐ neck pain ☐ Arm pain/weakness/numbness ☐ Back pain ☐ Leg pain/weakness/numbness
Skin/Breast: ☐ rash ☐ skin peeling ☐ breast enlargement ☐ milk from the nipple
Neurological: ☐ headaches ☐ Dizziness ☐ seizure ☐ vertigo ☐ Trouble speaking ☐ in coordination
Psychiatric: ☐ depression ☐ anxiety ☐ Trouble sleeping ☐ Memory loss
Endocrine: ☐ frequent urination ☐ frequent thirst ☐ cold/heat intolerance ☐ tremors ☐ recent gain in weight
Hematology: ☐ Anemia ☐ easy bruising ☐ leukemia ☐ lymphoma
Allergic/Immunologic: ☐ post-nasal drip ☐ facial rash ☐ frequent infections ☐ diffuse joint swellings

PAST MEDICAL HISTORY:

Medical Illnesses		**Operations** (type and date)	
1. **Heart disease** ☐ Yes ☐ No	4.	1.	4.
2. **Diabetes** ☐ Yes ☐ No	5.	2.	5.
3. **High blood pressure** ☐ Yes ☐ No	6.	3.	6.

Current Medications		**Trauma** (type and date)	**Allergies**
1.	5.	1.	1. Reaction:
2.	6.	2.	2. Reaction:
3.	7.	3.	3. Reaction:
4.	8.	4.	4. Reaction:

FAMILY HISTORY:

Father: What age_____ ☐ Living ☐ Deceased Cause of Death_____

☐ Negative ☐ Heart disease ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Mental ☐ Cancer ☐ Other _____

Mother: What age_____ ☐ Living ☐ Deceased Cause of Death_____

☐ Negative ☐ Heart disease ☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Mental ☐ Cancer ☐ Other _____

SOCIAL HISTORY: ☐ single ☐ married ☐ divorced ☐ widowed ☐ children #_____ ☐ living with_____

Work status: ☐ part-time ☐ full time ☐ sick leave ☐ disabled, last day worked _____ ☐ unemployed ☐ retired

Litigation: Active ☐ Yes ☐ No Settled ☐ Yes ☐ No

Weight_____ **Height**_____ **BMI**_____ **BP**_____ ☐ **Right-handed** ☐ **Left-handed**

_____
Patient Initials (Guardian Initials if patient is a minor)

In the past year, have you fallen?

☐ Yes

☐ No

IF YES:

In the past year, how many falls have you had?

☐ One fall with injury
☐ Two or more falls with injury
☐ One fall without injury
☐ Two or more falls without injury

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

IF YES:

How often did you have a drink in the past year?

☐ Monthly or less
☐ 2 – 4 times a month
☐ 2 – 3 times a week
☐ 4 or more times a week

How many drinks did you have on a typical day in the past year

☐ 1-2
☐ 3-4
☐ 5-6
☐ 7-9
☐ 10 or more

How often did you have 6 or more drinks on one occasion

☐ Never
☐ Less than monthly
☐ Monthly
☐ Weekly
☐ Daily or almost daily

Signature:_____ Date:_____

Providence Park
26850 Providence Parkway
Suite 240
Novi, MI 48374

Providence Medical Office Building
22250 Providence Drive
Suite 601
Southfield, MI 48075

St. John Macomb
11900 East 12 Mile Road
Suite 206
Warren, MI 48093

MICHIGAN SPINE & BRAIN SURGEONS PLLC

Transition of Care

Before your visit today, have you been to the following:

☐ER ☐Urgent care facility ☐Rehab facility ☐A physician's office ☐Hospital for surgery

If yes, please indicate the date and reason for your visit:

Date	Reason

Tobacco Control: Check every box which applies

☐ **Never Smoked**

☐ **Current Smoker** What date did you start smoking? ____/___/_____

How often do you smoke cigarettes?
- ☐ every day
- ☐ some days

How many cigarettes a day do you smoke?
- ☐ 5 or less
- ☐ 6-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 or more

How soon after you wake up do you smoke?
- ☐ within 5 minutes
- ☐ 6-30 minutes
- ☐ 31-60 minutes
- ☐ after 60 minutes

Are you interested in quitting?
- ☐ ready to quit
- ☐ thinking about quitting
- ☐ not ready to quit

☐ **Former Smoker** What date did you start smoking? ____/___/_____

What date did you stop smoking? ____/___/_____

How long has it been since you last smoked?
- ☐ < 1 month
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 1-5 years
- ☐ 5-10 years
- ☐ > 10 years

Signature: _____ Date:_____

Providence Park
26850 Providence Parkway
Suite 240
Novi, MI 48374

Providence Medical Office Building
22250 Providence Drive
Suite 601
Southfield, MI 48075

St. John Macomb
11900 East 12 Mile Road
Suite 206
Warren, MI 48093

Pharmacy Request Letter

Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street or major crossroads, city, phone, fax) as any information provided will be helpful.

PHARMACY:

Name (i.e. CVS, Rite-Aid, etc): _____

Street Address: _____

City: _____

Phone:_____ Fax: _____

This office may ePrescribe and view my external history prescriptions: ***yes*** or ***no*** (answer required, please circle one)

_____

Patient Initials (Guardian Initials if patient is a minor)

Michigan Spine and Brain Surgeons, P.L.L.C.

Consent for Communication via Email or Text Messages

Text message outside of a secure portal is not HIPAA compliant. Please do not send text message to our office or surgeons.

Michigan Spine and Brain Surgeons offer patients the opportunity to communicate by email. Please consider the risks with transmitting patient information by email:

Email is not inherently secure. Email messages pass between hundreds of computers before arriving at the addressed destination, risking interception. Email can also be forwarded to other recipients without the original sender's permission. Do not put sensitive subject matter in your email.

If you send emails from your employer's computer, your employer will have access to your emails. Employers have a right to archive and inspect emails through their system.

Email senders can easily misaddress an email, which can be immediately broadcasted worldwide to many intended and unintended recipients.

Email communication with Michigan Spine and Brain Surgeons is only offered to established patients. Please acknowledge the following when communicating by email with any physician:

Please understand that emergency needs cannot be met by email. If it is an urgent matter, please call our office or go to the nearest emergency room.

Email is not a substitute for an office visit and/or physical examination. It is only a convenient means to address simple issues. If your inquiry is deemed too complicated for email correspondence, you will be directed to schedule an appointment.

New health issues will not be addressed via email. If your symptoms have changed, please call as soon as possible to make an appointment to see your physician in the office.

Copies of your email correspondence will be kept in your chart.

Email is not checked outside of normal business hours. While receipt of your email will be acknowledged within 48 hours, depending on the issue involved, the time frame may vary for the resolution of the underlying inquiry.

If you abuse your email privileges, such electronic interaction may be terminated at any time and your messages will not be read.

All patients are required to sign this informed consent form for use of email regarding health protected information. If you have not signed the consent with us before sending an email, we will send you the consent form for a signature before we will address your inquiry through email.

Should I choose to communicate with the physicians at Michigan Spine and Brain Surgeons through email or text message, I understand that electronic communication is not 100% reliable or secure. I acknowledge that security breach may occur despite efforts by the practice to protect my privacy.

If I refuse to participate in email or text messages, the default methods of contact will be phone and mail. These two options are necessary for me to remain under the care of Michigan Spine and Brain Surgeons, PLLC.

_____ _____

Patient Initials (Guardian Initials if patient is a minor) Date

Version 04.06.2018

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. The "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records without your authorization only for each of the following purposes:

- **Treatment**: providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment**: such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations:** includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Certain other uses and disclosures that do not require consent

- **When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement**. We may disclose when a law requires that we report information to government agencies about victims of abuse, or domestic violence.
- **For public health activities.** We provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
- **For health oversight activities.** We will provide information to assist the government when it conducts an investigation or inspection of a health care provider.
- **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ donations and transplants.
- **To avoid harm.** We may provide information to law enforcement in order to avoid a serious threat to the health or safety of a person or public.
- **For specific government functions.** We may provide information to law enforcement for national security purposes.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. An example of this would be studying surgery outcomes in research.

We may contact you to provide appointment reminders or information about treatment or other health-related benefits and services that are requested by you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to abide by that written request, except to the extent that we have already taken actions according to your initial authorization.

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
NOTICE OF PRIVACY PRACTICES

We may follow more stringent Michigan Law, for example minors may seek treatment without parental consent for certain conditions; however, we may notify the parents or guardians of the treatment without the minors' consent.

Workers' compensation cases are exempt from the HIPAA requirement. This means a caseworker can request any part of your medical records or information without your written authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain use and disclosure of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and obtain a copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint about violations of the provisions of this notice. We will not retaliate against you for filing a complaint.

I have read and understood this notice.

_____ _____

Patient Initials (Guardian Initials if patient is a minor) Date

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
eClinicalWorks Patient Portal – Consent Form

Purpose of this Form:

Michigan Spine and Brain Surgeons PLLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:
1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, please call our office or go to the nearest emergency room.

If there is information that you don't want transmitted via online communication, please inform our office.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

_____ _____

Patient Initials (Guardians Initials if patient is a minor) Date

Michigan Spine and Brain Surgeons General Information

Thank you for choosing our practice, we appreciate the trust you have placed in us.

WAIT TIME

Our doctors spend as much time as necessary in order to answer all questions for patients, especially those scheduling surgery. Please allow enough time, as the wait time is unpredictable and **the whole process may be up to 3 hours**.

WHAT TO BRING TO YOUR APPOINTMENT

Photo ID, Insurance card, co-pay and referral

Payment must be made at the time of service. If this payment is not received at the time of visit, you will be charged an additional fee or may be asked to reschedule your appointment.

- **For HMO policy holders**, a prior authorization and referral is required from your primary doctor
- **For Workman's Compensation or Auto-related injuries**, a letter of authorization from the insurance company on their letterhead is required or you, as the patient, will be liable to pay for the appointment upfront.

You must bring your driver's license and insurance card to your appointment. This has been implemented in order to reduce medical identity theft. You are also required to provide your full SSN.

Imaging:

- If your appointment is in our **Southfield, Novi or Macomb** location and you had your imaging done at a St. John Providence Imaging facility (Providence Southfield or Novi, St. John Macomb-Oakland, St. John Hospital in Grosse Pointe) you do not need to bring your Imaging studies to the appointment
- If the above situations do not apply to you, you are required to bring the actual imaging studies in the form of films or CDs (MRI, CT scans, X-rays, etc.) with the report, to the appointment
- If the images are not brought to the appointment, your appointment will be rescheduled

Medication

Please make sure to bring all medications to your visit. You may bring them in the bottle or in a written list.

FORMS AND MEDICAL RECORDS FEE SCHEDULE

It will take from 7 to 10 business days for any form to be completed by the physician, please allow adequate time for these forms to be processed.

**We complete disability forms only for patients who undergo surgery with us for a limited time preoperatively, and the acute recovery period postoperatively. We do not provide long-term chronic disability attestation, except in rare situations **

Fee Schedule

- Handicap driving permit: $15
- CD of X-rays taken in office: $10
- Medical Record Forms: First form after surgery is free of charge, then $30 per form
- If records are requested for or by an attorney: Cost is based on page count
- If records are requested for or by an auto insurance company: Cost is based on page count
- One office note copied for the patient: Cost is based on page count
- All records copied for the patient: Cost is based on page count
- Records will be sent to your primary care physician automatically. If records must go to another physician, you need to sign an authorization, and then the records will be sent free of charge.

For the most efficient use of your time, we ask that you fill out the enclosed forms and bring it with you to your first appointment. **Please make sure to provide the complete address, phone and fax numbers for your primary care and referring physicians.**

_____

Patient Initials (Guardian Initials if patient is a minor)

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
PRACTICE POLICY

Prescription policy: Our practice only prescribes narcotics for patients awaiting surgery and in the first 3 months following surgery. This is a surgical clinic and we do not prescribe or monitor long term use of pain medications. Long term pain management is referred to your own Primary Care Physician or the pain clinic.

Billing policy: It is your responsibility to be familiar with your insurance coverage. **The doctor renders service to you, the patient, and not to the insurance company, the insurance policy is between you and the insurance company, not with the doctor.** You, the patient or legal guardian of the patient, is legally responsible for charges resulting from services provided by the providers at Michigan Spine and Brain Surgeons, PLLC regardless of the existence of insurance or other third-party liability.

Medicare patients: If you have Medicare as your primary insurance and other insurance as your secondary insurance, you are expected to pay your secondary insurance's copay. We will bill Medicare and your secondary insurance for you. If you have **Medicare only,** you are expected to pay 20% of the Medicare fee schedule at the time of service.

For Workman's compensation or Auto-related injury patients: we require your claim number, the date of injury, the adjuster's name and contact information, the insurance carrier's name and address. We also require an authorization letter/letter of intent to the physician from the insurance company. If you fail to produce the above information, you will need to reschedule your appointment or pay the full fee at the time of service. Any legal action must remain between you and your attorney. We do not wait for legal settlement. Workman's compensation will be treated as a secondary insurance to your health insurance. We will reimburse you for any health insurance copay upon payment from workman's compensation or auto insurance.

For participating PPO insurance holders: you need to pay your co-pay and deductible at the time of service. We will bill the insurance for the remaining balance. However, if your policy does not cover particular services rendered, you will be responsible for the charges incurred.

For second opinion patients: some insurance policies will not cover second opinion visits. We will bill the insurance and you will be responsible for any amount not covered by the insurance. If you neglect to inform us that this is a second opinion, you will be responsible for the resultant billing error.

For BCBS master medical patients: you are required to pay the full fee at the time of service. We will bill the insurance on your behalf and the insurance payment will be directly sent to you.

If you **do not have insurance coverage or carry an insurance policy that our office does not participate with,** you will be responsible for all charges incurred. Please talk to us about our payment plan arrangement. We will be happy to assist you.

Our fees: we set fees in alignment with the Medicare fee schedule and geographically adjusted for Neurosurgical and Orthopedic specialist in the Michigan region. We do not accept the insurance industry's "usual and customary" fee schedule unless we participate with the insurance. **For non-participating insurances, any dispute regarding the fees charged and their definition of "usual and customary" is between you and your insurance carrier. If you are not satisfied with the insurance payment, it is up to you to contact your carrier.**

Please **inform us of any changes** so we may bill the proper carrier. This is **your** responsibility.

You will be charged a no show fee of $35 if you **do not show up** for your appointment or **do not call** to cancel or reschedule 24 hours in advance.

_____ _____

Patient Initials (Guardian Initials if patient is a minor) Date

MICHIGAN SPINE AND BRAIN SURGEONS PLLC
PRACTICE POLICY

If you show up later than your scheduled appointment time, you will be seen after the patients that were on time. We will **cancel** your appointment if you are more than 45 minutes later than your scheduled appointment time and you will be charged a no show fee.

At the time of service, you are expected to pay your medical fees not covered by your insurance carriers. Your co-pay and deductible are to be paid upon checking-in. If you are unable to pay your copay/balance at the time of visit, you may need to reschedule your appointment. Under special circumstances, you may be able to complete your appointment but there will be a $15.00 service charge for us to send you a statement. **This office accepts checks, credit cards and debit cards. Please be advised that the interest may be charged on all patient balances that are 90 days or more past due at a rate of 1.5% per month, or 18% per annum.**

ASSIGNMENT OF BENEFITS

I assign payment of authorized benefits to the surgeons of Michigan Spine and Brain Surgeons for services rendered. I understand that I am responsible for all charges not covered by my insurance policy.

AUTHORIZATION OF TREATMENT

I hereby authorize the physicians of Michigan Spine and Brain Surgeons, to furnish medical and surgical treatment as indicated and to acknowledge instructions for follow up care. I understand that in emergency situations it may be necessary or advisable for the physicians to perform other additional or extended services beyond those planned at the outset of care in order to preserve my (the patient's) life or health. I consent to these services and/or procedures. I further consent to the photographic, filming, recording or televising of the procedure(s) to be performed, including appropriate portions of my body, for medical or scientific research, or educational purposes. Information identifying me will not be disclosed.

CANCELLATION POLICY FOR VISITS AND SURGERIES

If I cancel or reschedule your appointment or surgery three times or more, I agree that the practice has the right to discharge me from the practice. I understand that each case is evaluated on an individual basis and exception may be made for contingencies.

RELEASE OF INFORMATION

I authorize the surgeons of Michigan Spine and Brain Surgeons, to release any medical or other information required in the coordination of care or requested by my insurance company to process a claim. I authorize Michigan Spine and Brain Surgeons to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including, but not limited to records of commercial pharmacies, i.e. Walgreens or CVS, and alcohol and other drug treatment records for verification of my medications.

HMO POLICY HOLDERS

A referral form is required from your primary doctor for any visits, tests or procedures, including surgery. It is your responsibility to bring all insurance information to the visit. If you fail to produce the referral form, you will need to reschedule your appointment or pay the full fee at the time of service. If you choose to be seen without a referral and do not obtain a retro-referral from your primary doctor, you will be billed for the visit.

RESEARCH AND TEACHING INSTITUTION

I have been informed that this facility is affiliated with a research/teaching institution and the medical and surgical procedures performed may require observation, cooperation and services of multiple healthcare providers, and I authorize such personnel to undertake this observation and care. In addition, I understand that this practice collect long term treatment outcome, necessitating the completion of outcome questionnaires either at the time of my visit, by phone or by other contact methods. My treatment and medical records may be reviewed by approved students and staff for teaching, studies and research purposes. Information identifying me will not be published without my prior consent.

_____ _____

Patient Initials (Guardian Initials if patient is a minor) Date

Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medicine you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- Our practice only prescribes narcotics for patients awaiting surgery and in the first 3 months following surgery. This is a surgical clinic and we do not prescribe or monitor long term use of pain medications. Long term pain management is referred to your own Primary Care Physician or the pain clinic.
- I agree to disclose a full list of medications that I am currently prescribed and taking.
- I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship.
- I understand that if I break this agreement, my doctor will stop prescribing these pain-control medications.
- I understand that my use of narcotic medication may impair my abilities, and thus I will not be able to operate heavy machinery, such as driving and that I should not make important decisions, or be at heights. I understand that this restriction will apply unless I have informed my doctor that I am able to carry out my activities of daily living without impairment.
- To ease the transition from taking narcotic medications, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. If needed, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
- I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours and will be prescribed within 48 business hours. No refills will be available during evenings or weekends.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigations of any possible misuse, sale or other diversions of my pain medicines.
- I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any application privilege, right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will bring all unused pain medication to every office visit.

I agree to follow these guidelines which have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

_____ _____

Patient Initials (Guardian Initials if patient is a minor) Date

Patient Provider Agreement

Providing the best possible care to every patient continues to be our primary goal. One way we can meet this goal is by working together to make your health and well being our number one mutual objective. This concept is called the Patient Centered Medical Home.

Patient Responsibilities:

- Ask questions, share your feelings and be part of your care
- Please be sure that you are current and accurate with your medical history, symptoms and other important information about your health
- Tell us about any changes in your health
- Take all of your medicine unless otherwise directed to stop
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Call us first with all problems, unless it is a medical emergency (call 911 or go to nearest emergency room)
- End every office visit with a clear understanding of our mutual expectations, treatment goals and future follow up visit plans

Physician Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to our patients' feelings and questions help them make decisions about their care.
- Keep treatments, discussions and records private
- Notify your Primary Care Physician (PCP) of cancellations and other actions that may place your care in jeopardy.
- Provide instructions on how to meet your health care needs when the office is not open
- Provide contact information for the provider's surgical scheduler
- Provide direct access to our billing department via instructions on the phone greeting and statement
- To care for you to the best of our abilities based on our understanding of current medical methods available
- Give our patients clear directions about medicines and other treatments
- Complete medication refill requests within 48 hours, if possible
- Return phone inquiries within 48 hours, if possible
- Complete medical records requests are completed in 7-10 business days
- Send our patients to trusted medical specialty experts if needed
- End every visit with clear instructions about expectations, treatment goals and future plans

Providence Medical Building
22250 Providence Drive
Suite 601
Southfield, MI 48075

Access to Care

- Our normal business hours are Monday – Friday from 8:30am – 5:00pm
- We provide same day appointments for urgent conditions
- We provide 24-hour access to medical care and phone access to our providers if necessary or in emergency
- ***We provide access to appointments before/after clinic hours in emergent cases***
- Contact our office at 248-569-7745 during or after normal business hours

Your Role in Coordination of Care

Coordination of care and communication back to your Primary Care Physician is your priority. Should you have other physicians managing your care please inform them that I am the specialist managing your spinal/neurological condition and that I require communication regarding any treatment that may affect my treatment plan.

- Should you have an AFTER-HOURS issue, especially if you have just undergone surgery, please contact me. I will direct you with the next steps.
- If you are not a recent surgery patient, and it is non-emergent, please visit an urgent care close to your home on the next business day.
- Should you have an issue not pertaining to neurology/spine, please contact your Primary Care Physician.
- Should you need a refill on a medication that I prescribed for you, please contact my office during business hours.

Ask any of our staff about Community Services or contact the following:

NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health, and social needs (i.e. utilities, housing, health insurance, food, diapers, etc.)

A listing of the area resources can also be found on this website:
http://www.referweb.net/uwjc

Ask about our Patient Web Portal

We have a Patient Portal that supports two-way, secure and compliant communication:
https://health.healow.com/mispineandbrain

I have read and understood all of the information contained in this packet. Any questions I had have been answered to my fullest understanding. I agree to abide by these agreements.

_____ _____

Patient Signature (Guardian Signature if patient is a minor) Date

Providence Medical Building
22250 Providence Drive
Suite 601
Southfield, MI 48075

Michigan Spine and Brain Surgeons, PLLC
Medical Lien & Assignment Agreement On Health Care Insurance Receivable

Patient Name:_____ ("Assignor")

Medical Provider:__Michigan Spine and Brain Surgeons, PLLC____("Assignee")

In exchange for the professional services for surgery and/or medical care, the following Lien and Assignment on Health Care Insurance Receivable shall be granted by Assignor to Assignee; in furtherance thereof, Assignor acknowledges the following:

Assignor acknowledges that he/she has incurred charges for medical services for which payment is due or is past due under a policy of insurance. Assignor acknowledges that Assignee has not only provided such medical services upon a promise of payment by Assignor, and Assignor's grant of this security interest, but Assignee may also assume the burden of enforcement of payment obligations for charges, no-fault interest, and attorney fees. This is an assignment to a health-care provider of a health-care-insurance receivable and any right to payment on all charges by any account debtor insurer or liable business entity.

As a means of cross collateralization of the security interest granted to Assignee, a lien is granted in the amount of all charges. This lien shall apply to proceeds acquired by Assignor through the exercise of any rights arising from any claim, cause of action, recovery, judgment, settlement or adjudication of any rights available to Assignor, whether raised against any individual or insurance company which was a proximate cause of the need for the medical services provided.

Assignor acknowledges and grants an assignment of any right to enforce payment of charges due or past due for medical services, from any policy of insurance, including but not limited to both health insurance and no-fault insurance, or any business entity, and shall include, in Assignee's sole discretion, the right to consider the party liable, appeal of a payment denial, and/or the right to file suit to enforce the payment of benefits due or past due, the right to pursue enforcement under any beneficiary or fiduciary rights of Assignee in any plan issued or managed pursuant to ERISA federal law, or self-insured entity, and the right to pursue all Assignee's rights to interest and attorney fees that may be a part of the available rights under any suit based upon a certificate of coverage in any primary non-group health plan, such as no-fault, and or an ERISA plan.

Assignee or its agent is designated as my attorney in fact with respect to any action taken in pursuit of payment of incurred charges, interest, and attorney fees under any policy of insurance or rights under Michigan law. This power of attorney is not intended to, nor does it allow Assignee to take any action on any claim unrelated to the Assignee's charges, interest due thereon, and/or attorney fees incurred in the pursuit of any Assignee action.

I further instruct my attorneys to treat the medical bill incurred by me from Assignee as a first lien upon any monies recovered, payable from whatever source, disclaiming any common fund, and to pay the amount of the lien in full, without regard to any costs or attorney fees that I may incur, before Assignor is to receive any funds. I further instruct my attorneys to advise Assignee as to the existence of any claim asserted on my behalf relating to the medical services provided, so that Assignee may seek its own counsel and representation to enforce this Lien and Assignment.

Assignor's liability will be discharged by payment of any funds arising from settlement or judgment from Assignor's suit or payment pursuant to the lien. This assignment does not extend to any future benefit in violation of MCL 500.3143.

This assignment shall be irrevocable. To the extent that any provision is determined to be unenforceable, it is my intent that the remaining provisions be enforced.

Patient Signature _____ ("Assignor")

Date _____/_____/_____