

**Michigan Orthopaedic Institute, P.C.**

[www.moimd.com](http://www.moimd.com)

Dear: \_\_\_\_\_

Thank you for requesting an appointment with the physicians of Michigan Orthopaedic Institute, P.C. Enclosed are a couple questionnaires for you to complete and bring to your appointment. If you need to cancel or reschedule this appointment, we request that you give us 48 hours notice when possible. **Please bring the following items with you to your first appointment:**

**INSURANCE CARD AND PICTURE ID.** If you are covered by more than one insurance company, please bring all cards with you.

**WORKERS COMPENSATION & AUTO ACCIDENTS PATIENTS WILL NEED AN OPEN CLAIM LETTER.** If you are being seen for a work related injury or an auto accident injury it is your responsibility to have a letter from your workers compensation/auto insurance companies that includes their billing address and states that you have an OPEN CLAIM with their authorization to be treated by our physician.

**HMO REFERRAL FORM:** If you are covered by an HMO or managed care insurance you MUST have a referral for all services performed in this office. You may bring the referral with you or arrange to have your Primary Care Physician fax or mail the form to us. You will be responsible for obtaining referrals for each visit to this office. **YOUR APPOINTMENT WILL BE RESCHEDULED IF NO REFERRAL IS AVAILABLE.**

**NEW PATIENTS ARE TO BRING ALL TESTING TO FIRST APPOINTMENTS. THIS INCLUDES MRI'S, CAT SCANS, EMG's, & BONE SCANS.** You must bring the actual films or a copy on CD-ROM. These films are necessary for our physicians to perform a complete evaluation of your condition.

**MEDICATION LIST AND PHARMACY INFORMATION:** All new patients must bring a complete list of all current medications and dosages. We also require the name, address and phone number of your pharmacy.

**WRITTEN REQUEST FROM YOUR REFERRING PHYSICIAN INDICATING REASON FOR VISIT.**

As a courtesy to you we will bill services directly to your insurance company. You are responsible for co pays, deductibles and non-covered office visits at the time of service. We gladly accept, cash, personal checks, Visa, MasterCard or American Express.

Thank you for choosing Michigan Orthopaedic Institute, P.C. for your healthcare needs. We appreciate the confidence you have placed in us and we'll do all we can to provide you with exceptional care in a pleasant environment.

Sincerely,  
**The Physicians and Staff of Michigan Orthopaedic Institute**

Appointment Date: \_\_\_\_\_

Appointment Time \_\_\_\_\_

**THE OFFICE YOUR APPOINTMENT IS SCHEDULED AT IS CIRCLED BELOW**

26025 Lahser Road  
2<sup>nd</sup> Floor  
Southfield, MI 48033  
248-663-1900

6900 Orchard Lake Road  
Suite 103  
W. Bloomfield, MI 48322  
248-855-7400

**PLEASE PRINT – FILL OUT TOP PORTION ONLY**

LAST _____	FIRST _____	MIDDLE _____	DATE _____
ADDRESS _____			PHONE# _____
CITY _____	STATE _____	ZIP _____	BIRTHDATE _____
PATIENT'S OCCUPATION _____			

MALE     FEMALE  
 SINGLE     MARRIED  
 WIDOWED     DIVORCED

**PATIENT SOCIAL SECURITY NUMBER** \_\_\_\_\_

**PATIENT EMPLOYED BY** \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

NAME OF SPOUSE OR PARENT \_\_\_\_\_ SPOUSE OR PARENT EMPLOYED BY \_\_\_\_\_

SPOUSE OR PARENT BUSINESS PHONE \_\_\_\_\_ SPOUSE OR PARENT SOCIAL SECURITY NUMBER \_\_\_\_\_

CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE# \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

PRIMARY DOCTOR \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

DO YOU WISH REPORTS SENT TO:    REFERRING DOCTOR \_\_\_\_ YES \_\_\_\_ NO    PRIMARY DOCTOR \_\_\_\_ YES \_\_\_\_ NO

**WHAT PROBLEM ARE YOU HERE FOR?** \_\_\_\_\_

**DATE OF INJURY / ONSET OF PROBLEM:** \_\_\_\_\_ **DATE LAST WORKED:** \_\_\_\_\_

**I DO / DO NOT (PLEASE CIRCLE ONE) GIVE PERMISSION TO LEAVE BASIC INFORMATION ON MY PERSONAL ANSWERING MACHINE**

**I DO / DO NOT (PLEASE CIRCLE ONE) GIVEN PERMISSION TO DISCUSS MY HEALTHCARE WITH FAMILY MEMBERS, PLEASE SPECIFY NAMES:**

**IS YOUR PROBLEM RELATED TO: (PLEASE CIRCLE ONE)**

WORKER'S COMP?    AUTO?    PUBLIC LIABILITY?    OTHER?

<b>IS THERE AN ATTORNEY INVOLVED IN THIS CASE?    YES    NO</b>	
NAME _____	
ADDRESS _____	
CITY _____	STATE _____    ZIP _____

**FOR OFFICE USE ONLY**

**WORKER'S COMPENSATION / AUTO AUTHORIZATION:**

DATE OF INJURY \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CLAIM NUMBER \_\_\_\_\_

ADJUSTER \_\_\_\_\_

PHONE \_\_\_\_\_

AUTHORIZED BY \_\_\_\_\_ PHONE \_\_\_\_\_ LETTER \_\_\_\_\_

**MEDICARE #** \_\_\_\_\_

**BLUE CROSS / BLUE SHIELD**

PREFERRED CARE _____	EFFECTIVE DATE _____
BLUE PREFERRED PLUS _____	ST. OF MI. _____
MESSA _____	COST SHARING _____
F.E.P. _____	TRADITIONAL _____
SUBSCRIBER NAME _____	
GROUP _____	BC    BS    BC/BS
CONTRACT _____	

NAME OF POLICY HOLDER _____	DATE OF BIRTH _____
NAME OF INSURANCE COMPANY _____	
ADDRESS _____	
CITY _____	STATE _____    ZIP _____
PHONE NUMBER _____	RELATIONSHIP TO PATIENT _____
GR# _____	ID# _____
NAME OF POLICY HOLDER _____	DATE OF BIRTH _____
NAME OF INSURANCE COMPANY _____	
ADDRESS _____	
CITY _____	STATE _____    ZIP _____
PHONE NUMBER _____	RELATIONSHIP TO PATIENT _____
GR# _____	ID# _____

# PATIENT HISTORY FORM

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ RETIRED: \_\_\_\_\_ STUDENT: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

HISTORY OF CHIEF COMPLAINT: \_\_\_\_\_

PREVIOUS TREATMENT: \_\_\_\_\_

PAST MEDICAL HISTORY: \_\_\_\_\_

PERTINENT FAMILY HISTORY: \_\_\_\_\_

\_\_\_\_\_

**DO YOU HAVE A PACEMAKER, DEFIBRILLATOR, OR CAROTID STENT?** YES \_\_\_\_\_ NO \_\_\_\_\_

HAVE YOU EVER RECEIVED TREATMENT FOR: *(please circle all that apply)*

- |                          |               |                  |                      |                       |
|--------------------------|---------------|------------------|----------------------|-----------------------|
| SKIN                     | DIABETES/ENDO | ARTHRITIS        | CIRCULATORY PROBLEMS | GOUT                  |
| LUNG                     | TRANSFUSION   | HIGH CHOLESTEROL | EPILEPSY             | PSYCHIATRIC CONDITION |
| BLOOD PRESSURE           | ACCIDENT      | BACK PROBLEMS    | GASTROINTESTINAL     | STROKE                |
| HEART                    | KIDNEY        | CANCER           | HEPATITIS/HIV        | NEUROVASCULAR DISEASE |
| LIVER                    | INFECTION     | CHEMOTHERAPY     | PHLEBITIS            |                       |
| MITRAL VALVE<br>PROLAPSE |               |                  | OTHER: _____         |                       |

SURGERIES: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

\_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

*(please circle yes or no)*

ARE YOU PREGNANT? YES NO

DO YOU SMOKE NOW? YES NO IF YES, HOW MANY PACKS PER DAY? \_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_

DID YOU EVER SMOKE?: YES NO IF YES, HOW MANY PACKS PER DAY? \_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_

ALCOHOL?: NONE SOCIAL MODERATE HEAVY

RECREATIONAL DRUGS?: YES NO IF YES, PLEASE LIST \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**REVIEW OF SYSTEMS**

*AT THE PRESENT TIME, DO YOU EXPERIENCE ANY OF THE FOLLOWING? (please circle yes or no)*

- Loss of bladder control? ..... YES NO
- Loss of bowel control? ..... YES NO
- Fever?..... YES NO
- More than 10 lb. involuntary weight loss?..... YES NO
- Chills?..... YES NO
- Night sweats? ..... YES NO
- Joint pains?..... YES NO
- Joint swelling? ..... YES NO
- Bleeding tendencies?..... YES NO
- Skin rashes?..... YES NO
- Bouts of depression or anxiety? ..... YES NO
- Numbness/tingling on face? ..... YES NO
- Loss of balance? ..... YES NO
- Tremors? ..... YES NO
- Hot flashes? ..... YES NO
- Excessive hair loss in a short period of time? ..... YES NO
- Iodine/Shellfish Allergies? ..... YES NO

**PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**KYLE ANDERSON, M.D.**  
Sports Medicine  
Arthroscopic Surgery  
Shoulder and Elbow Replacement  
**DAVID J. COLLON, M.D.**  
Sports Medicine  
Arthroscopic Surgery  
**THOMAS J. DITKOFF, M.D.**  
Pediatric Orthopaedics  
Adult Reconstructive Surgery  
Arthroscopy and Sports Injuries  
**PETER R. DONALDSON, M.D.**  
Sports Medicine  
**JEFFREY S. FISCHGRUND, M.D.**  
Disorders of the Spine  
Disc and Stenosis Surgery  
Reconstructive Surgery of the Neck and Back  
**HARRY N. HERKOWITZ, M.D.**  
Disorders of the Spine  
Disc and Stenosis Surgery  
Reconstructive Surgery of the Neck and Back  
**LIGE M. KAPLAN, M.D.**  
Total Joint Surgery of the Hip and Knee  
Minimally Invasive Hip and Knee Arthroplasty  
Revision Hip and Knee Surgery  
**LAWRENCE T. KURZ, M.D.**  
Adult and Children's Spinal Disorders  
Scoliosis  
Reconstructive Surgery of the Neck and Back  
**JERRY A. MATLEN, M.D.**  
Adult Reconstructive Orthopaedic Surgery  
Hip and Knee Joint Replacement

**MICHIGAN ORTHOPAEDIC INSTITUTE, P.C.**

ORTHOPAEDIC SURGERY  
&  
PHYSICAL MEDICINE

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26025 LAHSER ROAD, 2<sup>ND</sup> FLOOR  
SOUTHFIELD, MICHIGAN 48033  
Tel. (248) 663-1900 Fax (248) 663-1901

6900 ORCHARD LAKE ROAD, SUITE 103  
WEST BLOOMFIELD, MICHIGAN 48322  
Tel. (248) 855-7400 Fax (248) 626-6481

**RACHEL S. ROHDE, M.D.**  
Orthopaedic Upper Extremity Surgery  
Hand and Microvascular Surgery  
**JASON B. SADOWSKI, M.D.**  
Orthopaedic Traumatologist  
**GINO R. SESSA, M.D.**  
Physical Medicine & Rehabilitation  
Electromyography & Electrodiagnosis  
**JEFFREY D. SHAPIRO, M.D.**  
Knee and Shoulder Surgery  
Arthroscopic, Reconstructive and  
Joint Replacement Surgery  
Sports Medicine  
**PAUL S. SHAPIRO, M.D.**  
Hand and Upper Extremity Surgery  
Shoulder Surgery  
Microvascular Surgery  
**EERIC TRUUMEEES, M.D.**  
Adult and Children's Spinal Disorders  
Reconstructive Surgery of the Neck and Back  
**JAMES J. VERNER, M.D.**  
Total Joint Surgery of the Hip and Knee  
Revision Hip and Knee Surgery  
Minimally Invasive Hip and Knee Arthroplasty  
**SUSAN WEIR, M.D.**  
Physical Medicine & Rehabilitation  
Electromyography & Electrodiagnosis  
  
**MARTIN L. WEISSMAN, M.D.**  
Retired  
**KENNETH W. GITLIN, M.D.**  
Retired

**ASSIGNMENT OF BENEFITS:**

I acknowledge that if I do not pay in full for services rendered, on date of service, I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Michigan Orthopaedic Institute, P.C. A photocopy of this assignment is to be considered as valid as the original. I further authorize Michigan Orthopaedic Institute, P.C. be allowed to release any information regarding my treatment in order to receive payment. I acknowledge that if I do not pay for services that interest will be charged against my account at an annual rate of 6%.

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Patient/Policyholder

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Date

# MICHIGAN ORTHOPAEDIC INSTITUTE, P.C.

## Patient Disclosure: Consulting Agreements with Orthopaedic Companies

**Dear Patient:**

**We would like to inform you that many of our physicians have consulting agreements with various orthopaedic companies.**

**Your doctor has been active in his career with research and development of new implants and improved surgical instruments and techniques. As part of this work, they have worked under contract with orthopaedic companies, providing consulting services on new products and input on research and development. In addition your doctor may have given instructional lectures on implants and surgical techniques for other doctors and medical personnel. In return for this time and expertise, your doctor may have been paid a consulting fee.**

**Our offices may use products from a company one of our doctor's is a paid consultant for in the care of our patients, but also may use similar products from other implant manufacturers. We want to assure you that the selection of which product to use in your care-and the care of all our patients-is based only on what is best for the patient, not on which company makes the product.**

**All of our Orthopaedic surgeons are members of the American Academy of Orthopaedic Surgeons, (AAOS) which holds its members to extremely high ethical standards to ensure that even the appearance of a conflict of interest does not jeopardize the trust that patients place in our doctors.**

**AAOS has adopted Standards of Professionalism that require orthopaedic surgeon members to identify and disclose potential conflicts of interest to their patients, the public and colleagues. These standards also clearly articulate how and under what circumstances AAOS members may work with and be compensated by industry, as well as the penalties for failure to comply.**

**You can learn more about these Standards of Professionalism at the AAOS website: <http://www.aaos.org/industryrelationships>**

**It is important to our office that you are aware of these relationships with implant manufacturers, that our office puts the interests of patients first, and that we are available to answer any questions that you may have.**

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**Patient Printed Name**

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**Patient Signature**

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**Date**

# MICHIGAN ORTHOPAEDIC INSTITUTE, P.C.

## NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 – (HIPAA)

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

### A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By Federal and State Law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

**The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

### B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Michigan Orthopaedic Institute, P.C.  
26025 Lahser Road, 2<sup>nd</sup> Floor  
Southfield, MI 48033  
(248) 663-1907

### C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors, nurses, medical assistants, office staff, medical students, and residents—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third

parties that may be responsible for such costs such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost- management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a family member, friend or other person that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter, the person who accompanied the child, may have access to this child's medical information.
8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by Federal, State or Local Law.

#### **D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:

- a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement

- b. Concerning a death we believe has resulted from criminal conduct
  - c. Regarding criminal conduct at our offices
  - d. In response to a warrant, summons, court order, subpoena, or similar legal process
  - e. To identify/locate a suspect, material witness, fugitive or missing person
  - f. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients.** Our practice may release IIIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
  6. **Organ and Tissue Donation.** Our practice may release your IIIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
  7. **Research.** Our practice may use and disclose your IIIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
  8. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
  9. **Military.** Our practice may disclose your IIIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
  10. **National Security.** Our practice may disclose your IIIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
  11. **Inmates.** Our practice may disclose your IIIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
  12. **Workers' Compensation.** Our practice may release your IIIHI for workers' compensation and similar programs.

## **E. YOUR RIGHTS REGARDING YOUR IIIHI**

You have the following rights regarding the IIIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Michigan Orthopaedic Institute, P.C.** office that is providing you services, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our

use or disclosure of your IIIHI, you must make your request in writing to the **Michigan Orthopaedic Institute, P.C.** office that is providing you services. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
  - (b) whether you are requesting to limit our practice's use, disclosure or both; and
  - (c) to whom you want the limits to apply
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Michigan Orthopaedic Institute, P.C.** office that is providing you services in order to inspect and/or obtain a copy of your IIIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Michigan Orthopaedic Institute, P.C.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIIHI kept by or for the practice; (c) not part of the IIIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIIHI for non-treatment, non-payment or non-operations purposes. Use of your IIIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Michigan Orthopaedic Institute, P.C.** office you are receiving services from. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Michigan Orthopaedic Institute, P.C.** office you are receiving services from.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Michigan Orthopaedic Institute, P.C.** office you are receiving services from or our **Compliance Officer- Mrs. Karen Cleaver at 26025 Lahser Road, 2<sup>nd</sup> Floor, Southfield, Michigan, 48033.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIIHI may be revoked at any time in writing.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the **Michigan Orthopaedic Institute, P.C.** office you are receiving services from.

**Notice effective 5/1/2007**

## ACKNOWLEDGEMENT

I acknowledge that I have read/or received a copy of the Notice of Privacy and a copy of the office policies for MOIPC.

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Patient or Personal Representative Signature

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Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

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# MICHIGAN ORTHOPAEDIC INSTITUTE, P. C.

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26025 LAHSER ROAD  
2<sup>nd</sup> FLOOR  
SOUTHFIELD, MI 48033

6900 ORCHARD LAKE ROAD  
SUITE 103  
WEST BLOOMFIELD, MI 48322

Dear Valued Patient:

We would appreciate you taking a moment to review our office policies listed below.

## OFFICE HOURS

Monday	9:00am to 5:00pm
Tuesday	9:00am to 5:00pm
Wednesday	9:00am to 5:00pm
Thursday	9:00am to 5:00pm
Friday	9:00am to 4:00pm

## APPOINTMENTS

- \* Patients are seen on an appointment basis only. We try to maintain our daily schedule, however, being an Orthopaedic practice emergencies frequently arise. We appreciate your patience and understanding.
- \* At times there will be more than one health care provider in the office treating patients. Please do not become distressed if you notice a patient in the reception room being taken before you. This person is probably seeing a different health care provider than you.
- \* If you are unable to keep your appointment, we would appreciate at least a 24 hour notice.
- \* If you are more than 20 minutes late for your appointment, you may be asked to reschedule your appointment.

## PRESCRIPTIONS

- \* If you need a new prescription or a refill of your current medication, please allow the office two (2) days to process your request. All prescription requests need to be verified by your physician before they are filled.

(over)

## FEES AND PAYMENTS

- \* There will be a \$25.00 fee charged on all checks returned due to non-sufficient funds.
- \* We will complete one medical disability form per month at no charge to you. There will be a \$10.00 fee for each additional form.
- \* The fee to obtain a copy of your medical record is based on the guidelines set forth in a new state law and varies in price depending on the size of your medical record.
- \* Please allow five (5) to seven (7) business days to process your request.
- \* Due to new laws mandated by the U.S. Government pertaining to the privacy of your health information we must have a signed authorization by you, along with the name, address and phone number of all parties you wish your medical records be released to.
- \* All previous balances are due prior to your next appointment.
- \* All co-pays are due on date of service.
- \* Finance charges will be charged at a rate of .5% monthly 6% annually for unpaid bills over 90 days past due.

## REFERRALS

- \* If your insurance requires a referral or written authorization (workers compensation/auto) and we do not have one at the time of your appointment you will have to reschedule.

## INSURANCE

- \* We deal with numerous insurance companies, ALL with different benefit packages. Therefore, it is your responsibility to know your insurance benefits and to inform us of any special requirements you may have.
- \* If your insurance covers Durable Medical Equipment (DME), we will be happy to bill your insurance carrier. If you know your insurance will not cover DME at our facility, we will gladly provide you with a written prescription for you to use at another supplier.
- \* It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance carrier.

**PLEASE NOTIFY FRONT OFFICE STAFF OF ANY INSURANCE OR ADDRESS CHANGES!!!**

**Forms/Record Release**

Today's Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

\_\_\_\_\_ Call to pick up  
\_\_\_\_\_ Mail  
\_\_\_\_\_ Fax

*Please complete the following release of information request:*

*I hereby authorize and request MOI, P.C. to release the following information concerning my illness and/or treatment.*

\_\_\_\_\_ Release Records (please specify if you do not wish to have all dates of service released)  
\_\_\_\_\_ Complete Form

Release records/Send form(s) to:

Name \_\_\_\_\_

Address \_\_\_\_\_

Fax \_\_\_\_\_ Phone \_\_\_\_\_

Signed \_\_\_\_\_

*Patient or Representative Signature*

**PLEASE ALLOW 5-7 DAYS FOR PROCESSING**