

Michigan Orthopaedic Institute, P.C.

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
2nd 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?

FOR OFFICE USE ONLY

WORKER'S COMPENSATION / AUTO AUTHORIZATION:

IS THERE AN ATTORNEY INVOLVED IN THIS CASE? YES NO

NAME
 ADDRESS
 CITY STATE ZIP

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#

CONSENT

BY YOUR SIGNATURE BELOW, YOU GIVE DR. SCHECHET PERMISSION TO PERFORM THE FOLLOWING PROCEDURES (circle which applies):

EPIDURAL STEROID INJECTION – SACROILIAC INJECTION(S) – FACET INJECTION(S)

IMPORTANT: WE CANNOT PERFORM EPIDURALS IF YOU ARE TAKING ANY ANTICOAGULANTS-BLOOD THINNERS SUCH AS COUMADIN, PLAVIX OR HAVE ANY BLOOD CLOTTING DISORDERS. DO NOT DISCONTINUE SUCH MEDICATIONS WITHOUT FIRST CONSULTING WITH THE DOCTOR WHO PRESCRIBED THEM.

NOTE: PREGNANT WOMEN SHOULD NOT UNDERGO THESE PROCEDURES. IF YOU THINK YOU MAY BE PREGNANT, PLEASE CANCEL THE PROCEDURE.

MOST OF THE RISKS OF EPIDURALS OCCUR ONLY VERY RARELY. THEY INCLUDE, BUT ARE NOT LIMITED TO:

1) **SPINAL HEADACHE:** APPROXIMATELY 1-2% OF PATIENTS EXPERIENCE A SPINAL HEADACHE AFTER A LUMBAR EPIDURAL STEROID INJECTION. A SPINAL HEADACHE IS CHARACTERIZED BY WORSENING OF THE HEADACHE WHILE STANDING AND IT IS RELIEVED BY LYING DOWN. A SPINAL HEADACHE CAN CAUSE YOU TO MISS WORK. TYPICALLY, IT SUBSIDES IN 1-2 WEEKS. IT IS TREATED BY THE FOLLOWING:

- A. BEDREST
- B. DRINKING A LOT OF BEVERAGES CONTAINING CAFFEINE

2) INFECTION, NERVE DAMAGE, PARALYSIS, DEATH.

3) MAY MAKE PAIN PERMANENTLY WORSE.

NOTE: WE FREQUENTLY MUST PERFORM A SERIES OF THREE (3) EPIDURALS AT ROUGHLY BI-WEEKLY INTERVALS.

MOST OF THE RISKS OF FACET AND SACROILIAC INJECTIONS OCCUR VERY RARELY. THEY INCLUDE, BUT ARE NOT LIMITED TO:

1) INFECTION, NERVE DAMAGE, PARALYSIS, DEATH.

2) CAN MAKE PAIN PERMANENTLY WORSE.

YOU SHOULD HAVE SOMEONE WITH YOU TO TAKE YOU HOME IF YOU HAVE TAKEN VALIUM FOR THE PROCEDURE, OR AVAILABLE TO COME PICK YOU UP IF YOU DEVELOP A HEADACHE OR HAVE A REACTION.

AFTER THE PROCEDURE YOU SHOULD NOT DRIVE OR OPERATE MACHINERY UNTIL THE NEXT DAY, IF YOU HAVE TAKEN VALIUM. GENERALLY, AFTER THE PROCEDURE FOR THE REST OF THE DAY YOU SHOULD NOT ENGAGE IN STRENUOUS ACTIVITY.

NOTE: YOU DO NOT NEED TO DISCONTINUE DAILY ASPIRIN, DAILY MOTRIN, OR OTHER NON-STEROIDAL ANTI-INFLAMMATORIES.

NOTE: FOR ALL OF OUR INJECTIONS THE MEDICATION INJECTED IS METHYLPREDNISOLONE AND IT USUALLY TAKES 3 TO 5 DAYS TO WORK.

PATIENT NAME: (PLEASE PRINT) _____

PATIENT SIGNATURE: _____

DATE: _____

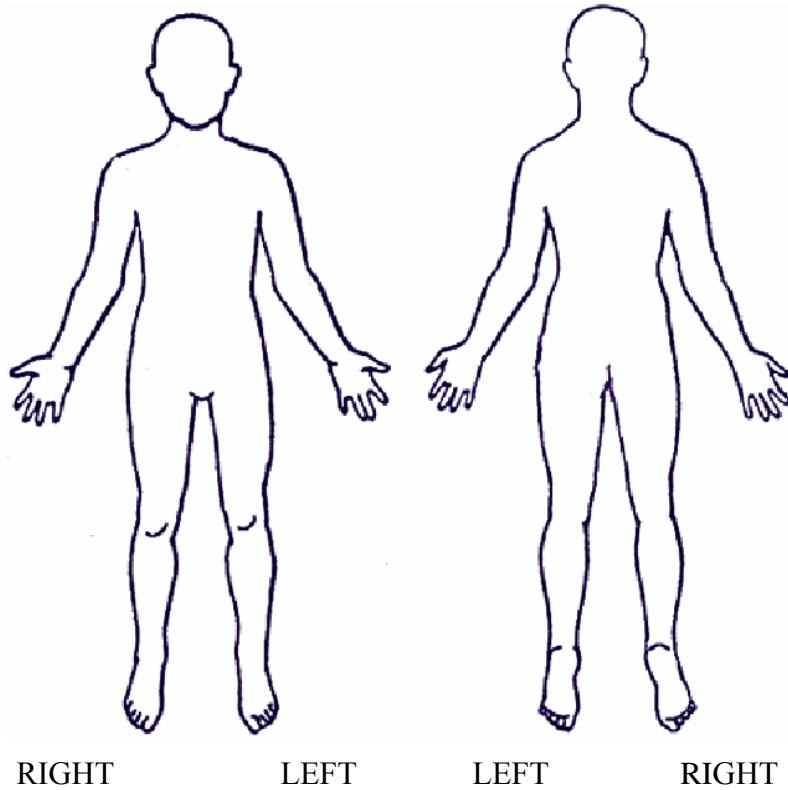
NOTE: CAUDAL EPIDURAL STEROID INJECTIONS ALMOST NEVER CAUSE SPINAL HEADACHES.

NAME: _____

DATE: _____

PAIN CLINIC

Please indicate on this diagram where your pain occurs by shading the painful area(s).



1. Approximately when did you first notice your pain?

Month _____ Year _____

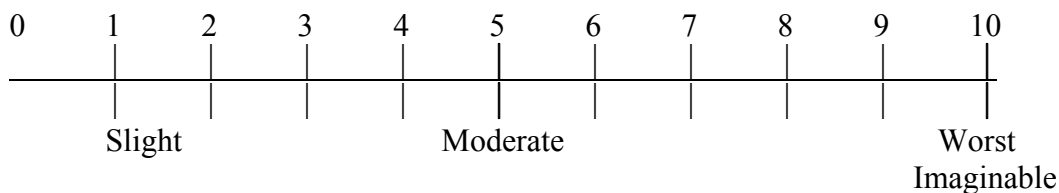
2. Under what circumstances did pain begin? (Check one)

- accident at work
- accident at home
- pain just began, no reason
- motor vehicle accident

3. Would you describe your pain as:

- Burning yes no
- Sharp yes no
- Aching yes no
- Throbbing yes no
- Shooting yes no

4. Please mark where your pain generally is (0 being no pain and 10 being worst pain imaginable).



5. Do you have:

- Numbness? yes no
- Tingling, pins and needles? yes no
- Weakness? yes no
- Muscle spasm, tightness? yes no

6. Does pain interrupt your sleep? (Check one)

- Never
- One to three times per night
- I hardly sleep at all due to pain

7. If you were injured at work, describe how?

- fall struck by object
- lifting object injury from repetitive
- pushing other (describe) _____
- struck by falling object _____

8. If injury resulted from motor vehicle accident, were you:

- driving automobile/truck
- automobile/truck passenger
- driving motorcycle
- motorcycle passenger
- pedestrian

9. Have you tried:

- Physical therapy? yes no
If yes, did it help? yes no
- Chiropractic treatment? yes no
If yes, did it help? yes no
- Acupuncture? yes no
If yes, did it help? yes no

10. Please list all types of surgery:

Type of Surgery	Approximate Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Please continue on other side of this sheet if there are more surgeries)

11. Have you had any of the following?

- X-ray
- Myelogram
- EMG
- MRI scan
- CAT or CT scan
- Bone scan
- Other (describe): _____

12. Have you had nerve block injections for pain relief? yes no

If yes, did injections help? yes no

Did you have any headaches after injection? yes no

13. Have you gained weight in the last few months? yes no

If yes, were you trying to gain weight? yes no

If yes, how much? less than 10 pounds

11 to 20 pounds

more than 20 pounds

Have you lost weight in the last few months? yes no

If yes, were you trying to lose weight? yes no

If yes, how much? less than 10 pounds

11 to 20 pounds

more than 20 pounds

14. Are you employed now? yes no

If yes, what kind of work? _____

If no, what kind of work did you do? _____

15. Are you a recovered/recovering alcoholic? yes no
 16. Are you a recovered/recovering drug addict? yes no
 17. Do you smoke? yes no

18. Check any of the following that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy <input type="checkbox"/> Convulsions <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin <input type="checkbox"/> Pills |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart attack (year:____) | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> currently <input type="checkbox"/> not currently | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Suicide attempt in past | <input type="checkbox"/> currently <input type="checkbox"/> not currently | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Drug overdose | (wet pants a lot) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Manic-depression | <input type="checkbox"/> chronic <input type="checkbox"/> recent onset | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Angina | (go in pants a lot) | Where: _____ |
| | <input type="checkbox"/> chronic <input type="checkbox"/> recent onset | _____ |
| | <input type="checkbox"/> Liver disease | _____ |
| | <input type="checkbox"/> Prostate enlargement | |
| | <input type="checkbox"/> Difficulty emptying | <input type="checkbox"/> Other: _____ |
| | | _____ |

19. Are you currently having an infection anywhere? yes no
 If yes, where? _____

20. Are you ALLERGIC to any medications? yes no
 If yes, please list: _____

21. Please list all medications you take:

- | | | |
|----|----|-----|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

22. Please circle or list any pain medication that you have tried in the past:

Neurontin, Elavil, Lortab, Vicodin, Vicodin-ES, Percocet, Bextra, Celebrex, Midrin, Mobic, OxyContin, Vioxx, Methadone, MS Contin, Ultram, Ultracet

Other: _____

Which pain medications, if any, have helped? _____

23. Are you taking Coumadin or Warfarin? yes no

24. Are you taking Plavix, Ticlid, Clopidogrel, or Ticlopidine? yes no

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

26025 LAHSER ROAD, 2ND 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%.

Patient/Policyholder

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.

Patient Printed Name

Patient Signature

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, 2nd 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, 2nd 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.

Patient or Personal Representative Signature

Date

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

MICHIGAN ORTHOPAEDIC INSTITUTE, P. C.

26025 LAHSER ROAD
2nd 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