

**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			<b>PATIENT SOCIAL SECURITY NUMBER</b>

MALE     FEMALE  
 SINGLE     MARRIED  
 WIDOWED     DIVORCED

**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#
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REFERRING SOURCE	ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
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DOCTOR REFERRAL	ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
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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:**

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 _____	

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

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**

## **ACKNOWLEDGEMENT**

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I acknowledge that I have received 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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# NOTICE OF PRIVACY

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

## I. OUR OBLIGATIONS

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Michigan Orthopaedic Institute, P.C. is required by law to protect the privacy of its health information, and to advise you of your legal rights as to how we maintain any and all records pertaining to the care and services you receive at Michigan Orthopaedic Institute, P.C. You have a right to receive adequate notice of all uses and disclosures by Michigan Orthopaedic Institute, P.C.

In this Notice, we explain how we protect the privacy of your Protected Health Information (“PHI”), and how we will allow it to be used and given out (“disclosed”). We must follow the privacy practices described in this Notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace or modify it.

This Notice is applicable to all of the records of your medical care generated by Michigan Orthopaedic Institute, P.C., whether made by office personnel, or your physician.

If you have any further questions about any section of this Notice or if you want to receive additional information about the health privacy procedures at Michigan Orthopaedic Institute, P.C., please contact:

Privacy Officer  
Michigan Orthopaedic Institute, P.C.

26025 Lahser Road	6900 Orchard Lk Rd
2nd Floor	Suite 103
Southfield, MI 48033	W Bloomfield MI 48322
(248) 663-1900	(248) 855-7400

## II. WHO IS SUBJECT TO THIS NOTICE

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This Notice describes our practices and the required privacy procedures of the following:

- Any of our health care professionals with authorization to enter information into your chart or medical records.
- All employees, staff and other Michigan Orthopaedic Institute, P.C. personnel.

## III. WHAT WE ARE OBLIGATED BY LAW TO DO

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We will follow the conditions set forth in this Notice of Privacy including:

# MOIPC

- Provide you with our Notice of Privacy which informs you of our legal obligations with respect to your medical information.
- Maintain all health information concerning your care according to the privacy requirements of the law.

## **A. How we may use or disclose your private health information:**

We are describing the following categories that pertain to how we may use and disclose any medical information about you. For some of these categories, we will provide examples of our privacy procedures.

**1. Treatment** We may use health information which concerns you to provide either medical treatment or services. We may disclose information about you to treating doctors, nurses, lab technicians, or other Michigan Orthopaedic Institute, P.C. personnel who are providing treatment to you. For example, if blood or urine specimens are drawn at our office, we may have to provide the results to consulting doctors' offices. Or, Michigan Orthopaedic Institute, P.C. may have to coordinate medical information about you with other departments at various hospitals or laboratories, such as diagnostic centers, pharmacies, etc. We may also find it necessary, in order to provide optimum medical care, to disclose medical information about you to individuals outside our organization, such as your family members, trusted friends, clergy, or others that we may be in contact with to assist us in providing services as a part of your care and

treatment. We may also at times need to leave messages on your answering machine.

**2. Payment** We may use and disclose health information about you in order for our organization to bill for the treatment and care you receive. In order to collect fees for our services and treatment, it may be necessary to bill either you, an insurance company or a third party. For example, we may find it necessary to disclose information concerning your health care to your health plan insurer about medical treatment or lab work which you received at our office in order to obtain payment for those services. Or, we may need to disclose private medical information to your health plan when your doctor recommends a procedure, such as knee surgery which can be scheduled in advance, in order to obtain the necessary prior approval for coverage from the insurer.

**3. Health Care Operations** We may use and disclose health information pertaining to your care and treatment at our organization in order to implement our health care operations in the most productive manner. For example, we may determine that it is necessary to utilize medical information from your records to review our staff policies concerning treatment. We may also compile statistics from your records together with other patient's files in order to determine if certain medical techniques are effective, and if we need to consider new treatments. We may compare medical information from your records with information from other hospitals or physician offices to determine how we may improve delivery of our medical services.

## **B. Uses and Disclosures Which DO NOT Require Authorization**

**1. Public Safety** We may use and disclose health information about you when it is necessary to prevent a serious and imminent threat to your health and safety or the health and safety of the public or another individual. However, any disclosure we may feel necessary to implement would only be to an individual in a position to counter the threat.

**2. Research** We may disclose your health information to researchers who are conducting research which has been approved by an Institutional Review Board or Michigan Orthopaedic Institute, P.C. privacy board. All projects are subject to special approval process, and will focus on balancing the patient's privacy and certain research goals. If it is necessary for the researcher to have access to your name, address or other pertinent information, we will request your specific permissions.

**3. Public Health Safety Issues** It is required by law that under the following circumstances, we may disclose your health information to public health authorities for reasons related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect, or domestic violence; reporting to the Food and Drug Administration regarding any problems with reactions to medications or products; notification regarding an individual who may have been exposed to a disease or who

may be at risk for contracting or spreading a disease or condition.

**4. Health Oversight Activities** We may disclose health information to health agencies for activities related to audits, investigations, inspections, and licensure proceedings. This is required in order for the government to monitor the health care system, government programs, and compliance with civil rights statutes.

**5. Required By Law** We will disclose your health information when we are required to do so by federal, state or local law.

**6. Judicial and Administrative Matters** If you become involved in any judicial dispute or administrative proceeding, we may disclose health information about you when necessary to respond to a court or administrative order. Further, we may also disclose health information concerning you if required to do so in response to a subpoena, discovery request, or other lawful process by another individual who may be involved in the dispute but we will disclose such information only if we have attempted to advise you of the request or to obtain a protective order for the requested information.

**7. Law Enforcement** We may disclose your health information to a law enforcement official or agency when requested to do so for the following purposes: identification or location of a suspect, fugitive, material witness or missing person; in response to a court order, subpoena, summons, warrant or other court

document; with regard to a crime victim if, under certain circumstances, we are unable to obtain your agreement.

**8. Workers Compensation** We may disclose health information about you in order to comply with workers compensation laws.

**9. National Security Issues** We may disclose health information about you to authorized federal officials for military, national security, intelligence, counterintelligence, and other national security issues required by law.

**10. Deceased Person Information** We may disclose your health information as requested by coroners, medical examiners and funeral directors.

**11. Military Service** We may disclose health information concerning you if you are a member of the armed forces as may be required by military command authorities.

## **C. Uses and Disclosures For Which You Have the Opportunity to Object.**

**1. Notification and Communication With Individuals Involved in Your Care** We may disclose your health information to notify or assist in notifying a family member, friend, your personal representative, or any other person who is responsible for your care. We may provide information to an individual who assists in paying for your care and treatment. We may

also divulge information about your condition to your family or friends as well as advising that you have been admitted to a hospital, if relevant. Also, we may disclose medical information which concerns you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are available to either agree or object, we will give you the opportunity to object prior to making this notification. If you are not in a condition to make this determination, then our health care professionals will use their best judgment in notifying your family and other concerned individuals.

## **IV. Your Health Information Rights**

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You have the right to request restrictions on certain uses and disclosures of your health information. Michigan Orthopaedic Institute, P.C. is not required to agree to a requested restriction. You have the following rights:

**A. Right to Request and Receive Confidential Communications.** You have the right to request that we communicate with you about health information through reasonable alternative means or at a certain location. For example, you may request that we only contact you at work or by mail. In order to request this information, you must submit your request in writing to the following:

Michigan Orthopaedic Institute, P.C.  
26025 Lahser Road      6900 Orchard Lk Rd  
2nd Floor                      Suite 103  
Southfield, MI 48033      W Bloomfield, MI 48322

We will not inquire as to the reason for your request. We will attempt to make all reasonable accommodations.

### **B. Accounting of**

**Disclosures** You have the right to request an accounting of certain disclosures of your health information. To receive the list of accounting of disclosures, you must submit your request in writing to the following:

Michigan Orthopaedic Institute, P.C.

26025 Lahser Road	6900 Orchard Lk Rd
2nd Floor	Suite 103
Southfield, MI 48033	W Bloomfield, MI 48322

Your request must indicate a time period that may not be lengthier than six (6) years and may not include dates prior to April 13, 2003. Your request should specify in what form you want the list. For example, on paper or electronically, etc. The first list which you request within a 12-month period will be sent to you at no cost. We may charge a reasonable, cost-based fee for each subsequent request within the 12 month period, provided that we inform you in advance of the fee and provide you with the opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

You have a right to obtain an accounting of disclosures of your health information except as to those disclosures relating to treatment, payment, health care operations, information provided by you, and certain government functions as indicated in the section entitled OUR OBLIGATIONS in this Notice of Privacy.

### **C. Right to Inspect and Copy.**

You have the right to inspect and copy your health information that may be used to make decisions about your care. This will usually apply to medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information which may be used to make decisions about you, you must submit your request in writing to the following:

Michigan Orthopaedic Institute, P.C.

26025 Lahser Road	6900 Orchard Lk Rd
2nd Floor	Suite 103
Southfield, MI 48033	W Bloomfield, MI 48322

If you request a copy of the information, we may assess a reasonable, cost-based fee for the costs of copying, mailing or other documents associated with your request.

**D. Right to Amend.** You have the right to request that your health information be amended if you believe the information is inaccurate or incomplete. Michigan Orthopaedic Institute, P.C. is not required to make the requested changes, but must provide you with a timely, written denial, and indicate on what basis you may complain to Michigan Orthopaedic Institute, P.C. about your disagreement with the denial.

You must submit your request in writing to:

Michigan Orthopaedic Institute, P.C.

26025 Lahser Road	6900 Orchard Lk Rd
2nd Floor	Suite 103
Southfield, MI 48033	W Bloomfield, MI 48322

Further, you must provide a reason which supports your request. We may deny your request if we determine that the amendment was not created by Michigan Orthopaedic Institute, P.C. is not part of your health records; is not information which you would be permitted to copy or inspect; or is accurate and complete.

### **E. Right to Request**

**Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information with regard to treatment, payment or health care operations. Michigan Orthopaedic Institute, P.C. is not required to agree to the requested restriction. If we do agree, we will abide by your request unless the information is required to provide you with emergency treatment.

To request restrictions, you must make certain that your request is in writing to the following:

Michigan Orthopaedic Institute, P.C.  
26025 Lahser Road      6900 Orchard Lk Rd  
2nd Floor                      Suite 103  
Southfield, MI 48033      W Bloomfield, MI 48322

In your request, you must advise us of the following:

- a. What information you want to limit;
- b. Whether you want to limit use or disclosure, or both; and

- c. To whom you want the limits to apply. For example, protecting confidentiality as to disclosures to your spouse, etc.

### **F. Right to Obtain a Paper Copy of this Notice.**

You have the right to receive a paper copy of this Notice upon request, and at any time. You are entitled to this paper copy even if you have received the Notice previously.

Also, you may obtain a copy of this Notice at our website,

[www.michiganspinecenter.com](http://www.michiganspinecenter.com) or  
[www.michiganorthogroup.com](http://www.michiganorthogroup.com).

To obtain a paper copy of this Notice, you may request it in person at the address listed below or you may submit it in writing to the following:

Michigan Orthopaedic Institute, P.C.  
26025 Lahser Road      6900 Orchard Lk Rd  
2nd Floor                      Suite 103  
Southfield, MI 48033      W Bloomfield, MI 48322

### **G. Changes to this Notice of Privacy.**

Michigan Orthopaedic Institute, P.C. reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information we already maintain on file about you or as to any information we may receive in the future.

### **H. Posting the Notice.**

We will post a copy of the current Notice in our offices at Michigan Orthopaedic Institute, P.C.:

26025 Lahser Rd                      6900 Orchard Lk Rd  
2nd Floor                                  Suite 103  
Southfield, MI 48033                  W Bloomfield, MI 48322

## **V. Other Uses of Medical Information.**

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Other uses and disclosures of health information not covered by this Notice or other applicable laws will be made only with your written permission through a written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons contained in your written authorization. You understand that we are unable to revoke any disclosures which we may have already made with your permission. Further, you understand that we are required to retain our records of the care and treatment which we provide to you.

## **VI. Complaints**

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You have the right to complain to Michigan Orthopaedic Institute, P.C. and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have not been honored. To file a complaint with Michigan Orthopaedic Institute P.C., you must contact the following:

Privacy Officer  
Michigan Orthopaedic Institute, P.C.

26025 Lahser Road	6900 Orchard Lk Rd
2nd Floor	Suite 103
Southfield, MI 48033	W Bloomfield, MI 48322

(248) 663-1900	(248) 855-7400
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If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Secretary of the Department of Health and Human Services, Washington, D.C.

We also advise you that the law prohibits retaliation against any individual who files a complaint.

# 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**