Name:
Chart: DOB:
Date:

WORKMAN'S COMPENSATION
PATIENT AGREEMENT

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

ALLEGED INJURY OR CHIEF COMPLAINT:

_____

_____

EMPLOYER INFORMATION AT THE TIME OF INJURY:

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

SUPERVISOR OR CONTACT: _____

WORKMAN'S COMPENSATION INSURANCE CARRIER AT THE TIME OF INJURY

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

CLAIM NUMBER: _____

CLAIM ADJUSTOR
OR CONTACT PERSON _____

We must have all of the above information to be able to bill your employer's workman's compensation insurance carrier for this injury. Should any of this information be incorrect or not completed, you, the patient, will be billed for all charges incurred by you for this injury.

Name:
Chart: DOB:
Date:

In addition to the workman's compensation information we must also at this time request a copy of your medical health card. Please be aware that this information is needed in case there should be a dispute or denial of your workman's compensation claim. We will not be billing this insurance unless a dispute or problem should arise with your workman's compensation claim.

Please read the three choices below and mark the appropriate box that shall pertain to yourself and this injury. Also please sign and date the bottom of this form. Thank you!

☐ **NO**, I will not provide **Center for Advanced Orthopedics & Sports Medicine, P.C.** with my medical insurance. I understand that should my workman's compensation claim be disputed or denied for any reason, I will be solely responsible for any charges provided to me. **Center for Advanced Orthopedics & Sports Medicine, P.C.** will not be able to bill my medical insurance in the future for this stated injury, should the need arise.

☐ **YES**, I am providing **Center for Advanced Orthopedics & Sports Medicine, P.C.** with a copy of my current medical insurance. I understand that should my workman's compensation claim not be paid by my employer's insurance carrier for any reason, **Center for Advanced Orthopedics & Sports Medicine, P.C.** will bill all charges incurred by me for this injury to my medical insurance. I also understand that **Center for Advanced Orthopedics & Sports Medicine, P.C.** cannot be responsible for any retro-referrals or authorizations and that this responsibility lies with me.

☐ **At this time**, I am not covered under any medical health insurance and understand that should my workman's compensation claims not be paid by my employer's insurance carrier for the reported injury for any reason, then I will be solely responsible for all charges incurred by me at **Center for Advanced Orthopedics & Sports Medicine, P.C.** for this injury.

Patient Signature Date

Name:
Chart: DOB:
Date:

PATIENT INFORMATION

Last Name _____ Legal First Name _____ Middle Initial _____
Sex _____ Social Security # _____ Birth date _____
Street Address _____ City, State, Zip _____ OK To Leave Msg __
Home Phone:_____ Work Phone: _____ Cell: _____
Email Address _____ @ _____ Prefers To Be Called _____

Race Choices: ☐ White ☐ American Indian ☐ Black ☐ Asian ☐ Type-Unknown_____
Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type-Unknown_____
Language Choices: ☐ English ☐ Chinese ☐ French ☐ Hebrew ☐ Hindi ☐ Japanese ☐ Portuguese
☐ Russian ☐ Yiddish ☐ Type - Unknown_____

SPOUSE INFORMATION

First Name_____ Last Name_____ Date of Birth _____
Work Phone _____ Emergency Contact Person ☐ Same as Spouse
☐ Other ☐ Relationship _____

WHO REFERRED YOU TO THE OFFICE?

Dr. Name _____ Phone _____ Hospital_____
Other_____

PRIMARY CARE PHYSICIAN: _____
Phone Number_____ Fax Number _____
Address _____
_____

RESPONSIBLE PARTY INFORMATION (PERSON'S NAME WHO APPEARS ON YOUR INSURANCE CARD)

NOTE: If your name is not the primary name on the insurance card, you are NOT the responsible party
Name on Card: _____ Date of Birth _____ SSN#_____
Address:_____ City _____ State ____ Zip _____
Employer Name _____ Occupation _____
Work Phone _____ Relationship _____

Attention Parents: It is the policy of this office that the parent who requests treatment for his/her child is responsible for all fees for service.

INSURANCE INFORMATION

PRIMARY INSURANCE

☐ **Blue Cross Blue Shield** ☐ **Medicare**
☐ **Medicaid** ☐ **Workers Comp**
☐ **Auto** ☐ **Other** _____
☐ **HAP**

SECONDARY INSURANCE:

☐ **Blue Cross Blue Shield** ☐ **Medicare**
☐ **Medicaid** ☐ **Workers Comp**
☐ **Auto** ☐ **Other** _____
☐ **HAP**

Name:
Chart: DOB:
Date:

CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Payment of your bill is part of this treatment and care. Your coverage by your health insurance carrier is unique to your policy. It is your responsibility to know and understand what your insurance plan will cover and pay.

We accept payment by cash, check, VISA, MasterCard, American Express and Discover. Care Credit is available and information is available. A $30.00 fee will be charged for non-sufficient funds.

When you register for the first time at our office you will be asked for some form of picture identification as well as your current insurance cards. We apologize for any inconvenience, but we have to ask for this information to protect you against insurance identify theft.

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, your appointment will be rescheduled.

If you are a patient presenting with back pain, your insurance company may require a separate spine care referral. Currently, Priority Health and Blue Care Network require specific spine care referrals. If you require further information regarding the spine care referral program, please ask to speak with one of our billing specialists.

Co-Payments are due on the day of visit. We are bound by contracts that we have signed with the insurance companies and waiving of any co-pays and/or deductibles is forbidden.

If your physician recommends surgery, you will be escorted to his Surgery Scheduler. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved and complete all pre-certification/authorization if your insurance company requires it. The Surgery Scheduler will request a pre-surgical deposit If you do not have health insurance to cover your surgery charges.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Center for Advanced Orthopedics and Sports Medicine. I authorize Center for Advanced Orthopedics and Sports Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date	Signature	Printed Name

Name:
Chart:
Date:

ORTHOPAEDIC HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

Is the current problem the result of a(n) ☐ Car Accident ☐ Work Accident ☐ Other

Date of Injury: _____ Please Describe: _____

Person to notify in case of an emergency:

Name: _____ Relationship: _____ Phone: _____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	REACTION
1.		
2.		
3.		

Primary Physician: _____ Address: _____

Referring Physician: _____ Address: _____

FAVORITE PHARMACY

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Name:
Chart:
Date:

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Cots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes - Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

Have you ever had general anesthesia? ☐ No ☐ Yes
Have you or any member of your family ever had problems with anesthesia? ☐ No ☐ Yes Please describe: _____

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	DOCTOR/HOSPTIAL
1.				
2.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Grandfather (maternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Grandmother (paternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Grandfather (paternal)	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Father	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Mother	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Brother/Sister	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Brother/Sister	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____
Other: _____	Y/N	____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke ☐ Other _____

Name:

Chart:

Date:

SOCIAL HISTORY

Occupation _____

☐ Full time ☐ Part time ☐ Retired
☐ Disabled ☐ Not Employed ☐ Student

Education
☐ High school ☐ Less than 8th grade
☐ 4 year college ☐ 2 year college
☐ Post graduate

Marital Status
☐ Divorced ☐ Married ☐ Single
☐ Domestic partner ☐ Separated ☐ Widowed

Exercise Level
☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Caffeine
☐ None
☐ Occasional
☐ Moderate
☐ Heavy
# of cups/cans per day? _____

Alcohol Do you drink alcohol?
☐ Yes ☐ No

If so, how often?
☐ Occasionally
☐ < 3 times a week
☐ > 3 times a week

How many drinks per week?
_____

Tobacco Do you use tobacco?
☐ Yes ☐ No
If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes - _____ pks./day
☐ Chew - _____ /day
☐ Cigars - _____ /day
☐ # of years _____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
☐ Frequent Sneezing
☐ Hives
☐ Itching
☐ Runny Nose
☐ Sinus Pressure

Cardiovascular
☐ Arm Pain on Exertion
☐ Chest Pain on Exertion
☐ Chest Heaviness/Pressure on Exertion
☐ Irregular Heart Beats (Palpitations)
☐ Known Heart Murmur
☐ Light-headed on Standing
☐ Shortness of Breath When Lying Down
☐ Shortness of Breath When Walking
☐ Swelling (edema)

Constitutional
☐ Exercise Intolerance
☐ Fatigue
☐ Fever
☐ Weight Gain (_____ lbs)
☐ Weight Loss (_____ lbs)

Eyes
☐ Dry Eyes
☐ Irritation
☐ Vision Change
Date of Last Exam: _____

Ears/Nose/Mouth/Throat
☐ Bleeding Gums
☐ Difficulty Hearing
☐ Dizziness
☐ Dry Mouth
☐ Ear Pain
☐ Frequent Infections
☐ Frequent Nosebleeds
☐ Hoarseness
☐ Mouth Breathing
☐ Mouth Ulcers
☐ Nose/Sinus Problems
☐ Ringing in Ears

Endocrine
☐ Fatigue
☐ Increased Thirst/Hunger/Urination

Gastrointestinal
☐ Abdominal Pain
☐ Black or Tarry Stool
☐ Blood in Stool
☐ Change in Appetite
☐ Frequent Indigestion
☐ Hemorrhoids
☐ Trouble Swallowing
☐ Vomiting
☐ Vomiting Blood

Genitourinary
☐ Blood in Urine
☐ Difficulty Urinating
☐ Incomplete Emptying
☐ Increased Urinary Frequency
☐ Urinary Loss of Control

Hematologic/Lymphatic
☐ Easy Bruising/Bleeding
☐ Swollen Glands

Integumentary (Skin)
☐ Changes in Moles
☐ Dry Skin
☐ Eczema
☐ Growth/Lesions
☐ Itching
☐ Jaundice (Yellow Skin/Eyes)
☐ Rash

Musculoskeletal
☐ Back Pain
☐ Joint Pain
☐ Muscle Aches
☐ Muscle Weakness

Neurological
☐ Dizziness
☐ Fainting
☐ Headaches
☐ Memory Loss
☐ Migraines
☐ Numbness
☐ Restless Legs
☐ Seizures
☐ Weakness

Psychiatric
☐ Alcohol Overuse
☐ Anxiety/Stress
☐ Depression
☐ Do Not Feel Safe in Relationship
☐ Mania
☐ Sleep Problems

Respiratory
☐ Cough
☐ Coughing Up Blood
☐ Shortness of Breath
☐ Sleep Apnea
☐ Snoring
☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

_____
_____
_____

_____ _____
Patient, Parent, Guardian, or Caregiver Signature Date

Name:
Chart: DOB:
Date:

Mykola J. Bartkiw, D.O.
Michael P. Donahue, D.O.
Christopher R. Nicholas, D.O.
John R. Olenyn, M.D.
Allen R. Prince, D.O.
Paul J. Siatczynski, M.D.
Sara Wierzbicki, PA-C

CENTER FOR
AdvancedOrthopedics
AND SPORTS MEDICINE

3100 Cross Creek Parkway #200
Auburn Hills, MI 48326
Tel (248) 377-8000
Fax (248) 377-2929
www.centerforao.com

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, , understand that as part of my health care, CAO originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* (located in the waiting room) that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that CAO is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CAO reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CAO change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

E-PRESCRIPTION CONSENT

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

I agree that Center for Advanced Orthopedics and Sports Medicine, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

At what number can you be reached? _____

May we leave a message on your voice mail/answering machine? ☐ Yes ☐ No

_____ _____
Patient's Signature Date

Name:
Chart: DOB:
Date:

Mykola J. Bartkiw, D.O.
Michael P. Donahue, D.O.
Christopher R. Nicholas, D.O.
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Dear Patient:

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

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

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

Patient Name: Date of Birth:

Home Phone: Work Phone: Cell Phone:

Please list your drug allergies or select "no known drug allergies":

☐ No known drug allergies

MAIN PHARMACY:

Name (e.g. CVS, Rite-Aid, etc) _____
Street Name & City _____
Phone: _____ Fax: _____

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:

Name (e.g. CVS, Rite-Aid, etc) _____
Street Name & City _____
Phone: _____ Fax: _____

Name (e.g. CVS, Rite-Aid, etc) _____
Street Name & City _____
Phone: _____ Fax: _____

THIS INFORMATION IS NOT PART OF THE MEDICAL RECORD ☐ Input into system