

**PATIENT INFORMATION**

please print

Date \_\_\_\_\_

- Single
- Married
- Widowed
- Divorced

BIRTHDATE: \_\_\_\_\_

AGE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

SEX:  M  F

Social Security Number: \_\_\_\_\_

Hand Dominant  R  L  Both

Patient Name \_\_\_\_\_

**Last**

**First**

**Middle Initial**

Address \_\_\_\_\_

**Number & Street**

**City**

**State**

**Zip**

Home Phone: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship & Name: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ Secondary Ins: \_\_\_\_\_

Are you the subscriber?  yes  no

Is the insurance in your name?  yes  no If no, subscriber name: \_\_\_\_\_

**SSN of subscriber:** \_\_\_\_\_ **Subscriber birthdate:** \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_  DR  Attorney  (self referral)

**Family Doctor:** \_\_\_\_\_

Address \_\_\_\_\_

**Number & Street**

**City**

**State**

**Zip**

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

**Were you seen in an emergency room for this problem?**  yes  no

**Hospital:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In this section, check the **ONE BOX** that best describes how your problem started, then answer the questions. Use as much space as needed in the comment section.

**Comments**

**No Injury** (onset was  gradual or  sudden) Why do you think it started? \_\_\_\_\_

**Injury** ( accident or  sport) Not auto or work Where & how did it happen? \_\_\_\_\_

**Injury at work** Date: \_\_\_\_\_ From a  lift  twist  fall  bend  pull  reach \_\_\_\_\_

**Auto accident** Date: \_\_\_\_\_ How was your vehicle hit? \_\_\_\_\_

## FINANCIAL POLICY

As the healthcare insurance industry increasingly drives the development of a “managed care” environment for both patients and doctors, it can easily become an overwhelming process for a patient to complete all the insurance forms. To help you determine what information and actions will be required on your part, we’ve outlined below some of the requirements of several types of insurance carriers. Our Front Desk and Billing staff will be happy to assist in answering any further questions you may have regarding this information.

**HMO/MANAGED CARE/ Participating Programs:** You are responsible for paying co-pays at the time of the visit and for obtaining any referrals/authorizations your plan may require before the visit. You are responsible to obtain your referral letter prior to your office visit. As per your agreement with your carrier, if you fail to take these steps you will be responsible for the entire payment. Otherwise, we will submit all charges and follow-up with your carrier for payment.

**NO-FAULT/WORKERS COMPENSATION:** You will need to provide our office with all information required to properly submit charges. Without this information, the fees mandated by the State of Michigan will be charged to reflect our private fees and you will be responsible for payment. Some no-fault carriers have deductibles on medical charges for which the patient is responsible. If you have private insurance with which we participate and obtain any referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

**MEDICAID:** You will need to provide our office with your Medicaid ID Card prior to your visit. If you are assigned to a HMO/Managed Care program through Medicaid, you will be responsible for obtaining all authorizations/referrals as outlined in the HMO/MANAGED CARE/Participating program section above. Please be aware, we do not participate with all of the Medicaid Programs through the State of Michigan (Cape & Molina).

**NON-PARTICIPATING CARRIERS:** You are responsible for full payment of charges at the time of the visit if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary billing information for the visit, we will submit the charge on your behalf to your carrier for reimbursement to you. You are responsible for following up with your insurance carrier regarding any unpaid claims and/or appeals.

**LIABILITY:** Carriers usually send payment to the patient or to the patient’s attorney if one has been retained. Our policy does not allow us to hold accounts that are pending resolution of any liability or litigation issues. We do not bill attorneys. If you provide a letter from the liability carrier indicating they accept full responsibility and will send payment, we will submit our bill to them on your behalf. Otherwise, you may either have charges submitted to your private carrier and pay for the services and obtain reimbursement upon resolution settlement.

**SELF-PAY:** If you are uninsured, you are responsible for payment in full at the time of service, unless prior arrangements have been made with the Billing Department. If you are unable to pay in full and need to discuss payment options available to you, you must contact our Office Manager at **(313)-277-6700, Monday – Friday 9:00 am – 4:00 pm.**

If you require further clarification of any of the policies described here, please contact our office at the number noted above. Thank you for your cooperation in this matter. I have read and or been advised to read the entire financial policy.

We accept cash, checks, MasterCard, Visa, Discover, and American Express.

### Authorization of Treatment/Assignment of Benefits/Release of Information

I hereby authorize treatment of the person named above and agree to pay all fees and charges for such treatment and I authorize my physician to release any information regarding my medical condition, including disability or employment related information concerning my claims for my insurance carrier(s), authorized agent(s) or attorney(s) for the purpose of validating and determining benefits payable in connection with my incurred medical expenses. I understand that my authorized representative or I may receive a copy of this authorization request. I also authorize direct payment of benefits to my attending physician and I understand that I am responsible for any amount not covered by insurance.

**Patient Name:** \_\_\_\_\_  
(please print)

**Signature of Patient/Guarantor:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Staff Initial:** \_\_\_\_\_

**Medical History:** (your health issues): check all that apply

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> None                | <input type="checkbox"/> thyroid disease                | <input type="checkbox"/> kidney disease              |
| <input type="checkbox"/> heart disease       | <input type="checkbox"/> liver disease                  | <input type="checkbox"/> cancer: _____               |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> ulcers                         | <input type="checkbox"/> acid reflux                 |
| <input type="checkbox"/> angina/chest pain   | <input type="checkbox"/> stroke                         | <input type="checkbox"/> bleeding/clotting problem   |
| <input type="checkbox"/> heart attack        | <input type="checkbox"/> seizures                       | <input type="checkbox"/> blindness/vision difficulty |
| <input type="checkbox"/> high cholesterol    | <input type="checkbox"/> diabetes                       | <input type="checkbox"/> substance abuse             |
| <input type="checkbox"/> asthma              | <input type="checkbox"/> tuberculosis                   | <input type="checkbox"/> mental disorder             |
| <input type="checkbox"/> COPD/emphysema      | <input type="checkbox"/> anemia/prior blood transfusion |  |

Other: \_\_\_\_\_

**Surgical History:** (list all surgeries and dates if known)

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**Family History:**     heart disease     diabetes     cancer     high blood pressure     arthritis

**Social History:**

Smoker:     no             yes \_\_\_packs/day             quit smoking \_\_\_\_\_(year)

Alcohol:     none             occasional             frequent (most days \_\_\_\_\_ drinks)

**Do you currently experience any of the following? (check all that apply)**

If none apply, check here

- |                           |  |  |   |
|---------------------------|--|--|---|
| <b>General:</b>           | <input type="checkbox"/> weight loss       | <input type="checkbox"/> fevers              | <input type="checkbox"/> fatigue        |
| <b>Cardiovascular:</b>    | <input type="checkbox"/> chest pain        | <input type="checkbox"/> irregular rhythm    | <input type="checkbox"/> heart murmur   |
| <b>Gastro intestinal:</b> | <input type="checkbox"/> heartburn         | <input type="checkbox"/> stomach ulcers      | <input type="checkbox"/> hepatitis      |
| <b>Musculoskeletal:</b>   | <input type="checkbox"/> arthritis         | <input type="checkbox"/> osteoporosis        | <input type="checkbox"/> prior fracture |
| <b>Neurological:</b>      | <input type="checkbox"/> dizziness         | <input type="checkbox"/> weakness            | <input type="checkbox"/> headaches      |
| <b>Respiratory:</b>       | <input type="checkbox"/> sleep apnea       | <input type="checkbox"/> shortness of breath |   |
| <b>Urinary:</b>           | <input type="checkbox"/> painful urination | <input type="checkbox"/> urinary infection   |   |
| <b>Endocrine:</b>         | <input type="checkbox"/> diabetes          | <input type="checkbox"/> thyroid problems    |   |
| <b>Hematology:</b>        | <input type="checkbox"/> blood clots       | <input type="checkbox"/> bleeding problems   |   |
| <b>Immunologic:</b>       | <input type="checkbox"/> tuberculosis      | <input type="checkbox"/> HIV/AIDS infection  |   |
| <b>Psychiatric:</b>       | <input type="checkbox"/> depression        | <input type="checkbox"/> anxiety             |   |
| <b>Eyes:</b>              | <input type="checkbox"/> need glasses      | <input type="checkbox"/> glaucoma            |   |
| <b>Ears/Nose/Throat:</b>  | <input type="checkbox"/> hearing loss      | <input type="checkbox"/> sinus infections    |   |
| <b>Skin:</b>              | <input type="checkbox"/> rash / sores      | <input type="checkbox"/> psoriasis           |   |

MEDICATIONS: \_\_\_\_\_  
(include non-prescription)

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Are you on blood thinners?  yes     no

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

What body part is involved? \_\_\_\_\_  right  left

What is the main reason for this visit?  pain  numbness  weakness  swelling  stiffness  
 other \_\_\_\_\_ When did it start? \_\_\_\_\_ (date)

Have you had a problem like this before?  yes  no If yes, when: \_\_\_\_\_

On a scale of 1-10 (10 is the worst), How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 (circle)

What is the quality of the pain?  sharp  dull  stabbing  throbbing  aching  burning

The pain is:  constant  comes and goes Does your pain wake you from sleep?  yes  no

Do you have  swelling  bruising  numbness  tingling  weakness  loss of bowel/bladder

Since my problem started, it is  getting better  getting worse  unchanged

What makes your symptoms worse?  standing  walking  squatting  exercising  twisting  
 sitting  stairs  lifting  kneeling  bending  coughing  sneezing  lying in bed

What makes your symptoms **better**?  rest  elevation  ice  heat  other \_\_\_\_\_

Have you had any of these treatments?

Injection:  yes  no brace:  yes  no physical therapy:  yes  no cane/crutch:  yes  no

What tests have you had for this problem?  x-rays  MRI  CT scan  bone scan  EMG

Have you had surgery for a problem in the same area either recently or in the past?  yes  no

If yes, previous surgery and date: \_\_\_\_\_

Current work status:  regular  light duty (how long? \_\_\_\_\_)  not working due to this problem  
 disabled  retired  student

When is the last date you worked your regular job? \_\_\_\_\_

Are you currently receiving or do you plan to apply for:

disability  yes  no workers' comp  yes  no unemployment  yes  no