Michigan Spine Institute
& PAIN MANAGEMENT

Steven M Rapp, M.D.
5220 Highland Rd., Suite 210
Waterford, MI 48327

O: (248) 383-1030
F: (248) 383-1031

Dear patient:

Thank you for selecting Michigan Spine Institute for your neurosurgical needs. We look forward to seeing you at your upcoming appointment on _____ at _____.

Enclosed you will find a new patient packet. Please fill out this paperwork prior to your first appointment and bring it with you. You will also find a map enclosed to help you locate our building.

You will need to bring photo identification and your insurance card(s) with you. If your insurance company requires a referral, you are responsible for obtaining it from your primary care physician. **If you do not have your insurance referral with you at the time of this and all future appointments, you will be rescheduled to another date and time.**

It is very important for you to bring any previous tests with you to this appointment. This includes X-ray films, CT scan films and MRI films. Please bring these tests in the form of a CD or the actual films. **The reports of these tests must also be obtained and brought with you to the appointment.**

Office hours are from 9am to 5pm Monday through Thursday, and 9am to 12pm on Fridays. Patients are seen by appointment only. Payment is expected at the time of service and will be accepted in cash, check, American Express, Mastercard or Visa.

Thank you for your kind cooperation.

Sincerely,
Steven M. Rapp, M.D.
Diplomat, American Board of Neurological Surgery

Michigan Spine Institute
& PAIN MANAGEMENT

WELCOME TO OUR OFFICE

Neurological Spine Surgery
Steven M. Rapp M.D. FACS

Anesthesia Pain Management
Judith G. Rapp, M.D.

Physician Assistant
Sheri A. Clements, P.A.C.
Halli E. Farber, P.A.C.

5220 Highland Rd.
Suite 210
Waterford, Michigan 48327
(248) 383-1030 office
(248) 383-1031 fax

OFFICE HOURS:

Office hours are from 90am to 5pm Monday through Thursday, and 9am to 12pm on Friday. Office visits are by appointment only.

TELEPHONE CALLS:
Telephone calls will be answered during regular business hours. If you call o leave a after hours, you will have the opportunity to leave a voice mail message.

FEES AND PAYMENT:
Office visit payment and co-pays are expected at the time of service. There is a $25.00 fee for copying medical records. For your convenience the office accepts cash, check, Visa, American Express, and Mastercard.

INSURANCE:
Please understand that your insurance policy is a contract between you and your insurance company. Claims will be submitted to your insurance carrier as long as you provide the necessary information. Due to the many changes in insurance policies, it is no longer possible to interpret each individual policy. It is your responsibility to know your individual coverage and to supply us with this information. If incorrect information causes a delay in billing, you may be held responsible for the cost of your care and treatment.

FORMS AND PRESCRIPTIONS:
Our office will complete one insurance form per claim at no charge. The completion of forms is done at the discretion of the doctor and should be discussed with him at the time of your visit. There will be a fee for any additional insurance forms. If you are requesting any prescriptions, please do so at the time of your visit. Subsequent refills may be requested via phone. The information will then be submitted for approval, and you will be notified once the medication has been called into the pharmacy. Again, the filling of prescriptions and refills are done at the discretion of the physician.

If you have any questions or concerns, please do not hesitate to call the office.

Your signature below verifies that you have read and understand the above information.

Signature: _____

Date: _____

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Patient Information (page 1)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ ST/ZIP: _____

Home Phone: _____ Alternate Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Marital Status (circle one): SINGLE MARRIED DIVORCED WIDOW/WIDOWER Sex (circle one): M F

Employer Name: _____ Occupation: _____

Employer Address: _____

Emergency Contact Person: _____ Phone: _____

Referring Physician (Name, Address, Phone Number) :

_____

Primary Care Physician (Name, Address, Phone Number):

_____

INSURANCE:

Primary Insurance Company: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Contract Number: _____ Group Number: _____

Subscriber Social Security Number: _____

Patient relationship to subscriber (circle one): SELF SPOUSE DEPENDENT

Subscriber's Employer / Retired From: _____

Employer's Address & Phone Number: _____

Secondary Insurance Company: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Contract Number: _____ Group Number: _____

Subscriber's Social Security Number: _____

Patient relationship to subscriber (circle one): SELF SPOUSE DEPENDENT

Subscriber's Employer / Retired From: _____

Employer's Address & Phone Number: _____

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Patient Information (page 2)

Patient's Name: _____

Is this the result of an auto accident: _____ Date of Injury: _____

AUTO ACCIDENT INFORMATION:

Auto Insurance Company: _____

Address of Claim Office: _____

Name of Claim Adjustor: _____ Phone: _____

Claim Number: _____ Policy Holder's Name: _____

State Accident Occurred In: _____

Is this a workers' compensation claim: _____ Date of Injury: _____

WORKERS" COMPENSATION CLAIM INFORMATION

Workers' Compensation Insurance Company: _____

Address of Claim Office: _____

Name of Claim Adjustor: _____ Phone: _____

Claim Number: _____

Please provide a letter of authorization from your employer or workers' compensation insurance company. If you do not have one, you are responsible to have a letter faxed to (248) 383-1031. Without written authorization for treatment, you will not be able to be evaluated.

AUTHORIZATION FOR INSURANCE AND MEDICAL INFORMATION:

Authorization to release information: I hereby authorize Michigan Spine Institute, P.C., to receive or release any medical or other information that may be necessary for my medical care or in processing insurance applications. This includes the sharing of information with all parties involved in my care. All means of data exchange may be utilized, including electronic transmission.

Assignment of insurance benefits: I hereby authorize direct payment of medical benefits to Michigan Spine Institute, P.C., for services rendered by one of their physicians or for services rendered under the supervision of a physician. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization for Medicare and Medicaid: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient Name (print): _____

Patient Signature: _____

Guardian's Name & Signature (if applicable): _____

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Patient Information (page 3)

Patient's Name: _____

Chief Complaint: _____

When did this begin? (specific date, if available): _____

When were you first treated: _____

Was this a car accident: _____ Was this an injury that happened at work: _____

Please describe in detail your injury and / or accident:

Past medical history (please list any current or past illnesses):

Past surgical history (please list all previous surgeries with dates):

Current medications with dose and frequency taken:

ALLERGIES to Medications: _____

What reaction(s) do you have to these medications: _____

Family History:
MOTHER - Living? Y or N List illnesses or cause of death: _____

FATHER - Living? Y or N List illnesses or cause of death: _____

Siblings - List illnesses: _____

Number of children: _____

Do you live alone: _____ If no, who do you live with? _____

Smoking History
Past: When did you quit? _____ Packs per day? _____ # of Years Smoked? _____

Present: Packs per day? _____ # of Years You've Smoked? _____

Alcohol use (circle one): DAILY WEEKLY MONTHLY RARE NEVER OTHER _____

Recreational Drug use (circle one): DAILY WEEKLY OCCASIONALLY RARE NEVER OTHER _____

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Patient Information (page 4)

Patient's Name: _____

Review of Systems - Are you currently or have you had a problem with:
If yes, please explain in space provided.

Constitutional		
Fever	N	Y
Weight loss	N	Y
Fatigue	N	Y
Night Sweats	N	Y
Eyes		
Infections	N	Y
Glaucoma	N	Y
Other;		
Ears, Nose, Throat		
Hearing Loss	N	Y
Ear pain/infection	N	Y
Ringing in ears	N	Y
Nasal drainage	N	Y
Sinus problems	N	Y
Sore throat	N	Y
Other:		
Cardiovascular		
Chest pain	N	Y
High blood pressure	N	Y
Irregular pulse	N	Y
Heart Murmur	N	Y
Edema	N	Y
High cholesterol	N	Y
Other:		
Respiratory		
Asthma	N	Y
Emphysema	N	Y
COPD	N	Y
Shortness of breath	N	Y
Lung Cancer	N	Y
Pneumonia	N	Y
Chronic bronchitis	N	Y
Endocrine		
Thyroid disease	N	Y
Diabetes	N	Y
Hormone problem	N	Y

Abdominal		
Nausea/Vomiting	N	Y
Abdominal pain	N	Y
Ulcers/gastritis	N	Y
Reflux disease	N	Y
Liver disease	N	Y
Jaundice	N	Y
Colon Cancer	N	Y
Genitourinary		
Infections	N	Y
Incontinence	N	Y
Prostate Cancer	N	Y
Uterine Cancer	N	Y
Cervical Cancer	N	Y
Other:		
Musculoskeletal		
Neck pain	N	Y
Arm weakness	N	Y
Back pain	N	Y
Leg weakness	N	Y
Joint pain/swelling	N	Y
Arthritis	N	Y
Numbness	N	Y
Other:		
Neurological		
Memory loss	N	Y
Seizures	N	Y
Dizziness	N	Y
Syncope (fainting)	N	Y
Slurred speech	N	Y
Blurred vision	N	Y
Loss of balance	N	Y
Facial weakness	N	Y
Headaches	N	Y
Brain Tumor	N	Y
Hematologic		
Bleeding disorder	N	Y
Anemia	N	Y

The above information is accurate to the best of my knowledge. (initial here please) _____

Information reviewed by: _____