Michigan Spine Institute
Steven M. Rapp, MD

5220 Highland Road, Suite 210
Waterford, MI 48327

(248) 383-1030 PHONE
(248) 383-1031 FAX

Dear Patient:

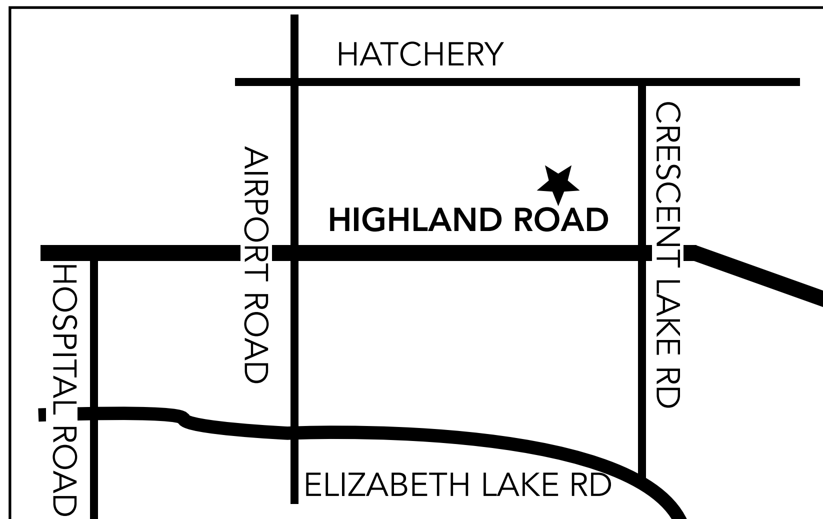
Thank you for selecting Michigan Spine Institute for your neurosurgical needs. We look forward to seeing you at your upcoming appointment on ________________ at ___________.

In order for our physician to give you the best care possible it will be necessary for you to bring the following items with you to your appointment:

Driver's License
Insurance Cards
Completed Forms Contained In This Packet
Insurance Referral (if you have: Priority Health, Blue Care Network, Blue Care Network Advantage, Health First, Health Plus, Total Health Care)
All Diagnostic Studies (X-ray's, MRI's, CT's, etc.) must be brought on CD or Film.

If you do not bring the items listed above, our physician will not be able to see you and we will have to reschedule your appointment to another date and time. Thank you in advance for your cooperation in providing this information.

Please call us with any questions, Monday through Thursday 9:00am - 5:00pm and Friday 9:00am - 12:00pm.



Michigan Spine Institute
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PATIENT DATA SHEET
FORM MUST BE COMPLETED IN FULL

FIRST NAME ____________ LAST NAME ____________ TODAY'S DATE ____________

ADDRESS ____________ CITY ____________ ST ______ ZIP ____________

HOME PHONE ____________ CELL PHONE ____________ WORK PHONE ____________

DATE OF BIRTH ____________ AGE ______ SEX ______ MARITAL STATUS ____________

HEIGHT ____________ WEIGHT ____________ SOCIAL SECURITY # ____________

REFERRING PHYSICIAN (NAME, ADDRESS, PHONE NUMBER)

____

PRIMARY CARE PHYSICIAN (NAME, ADDRESS, PHONE NUMBER)

____

EMPLOYER ____________ OCCUPATION ____________

EMPLOYER ADDRESS ____________

EMERGENCY CONTACT (Nearest relative or friend not living with you)

NAME ____________ RELATIONSHIP ____________ PHONE ____________

PRIMARY INSURANCE COMPANY ____________

SUBSCRIBER NAME ____________ SUBSCRIBER DATE OF BIRTH ____________

CONTRACT NUMBER ____________ GROUP NUMBER ____________

SUBSCRIBER SOC SEC # ____________ PATIENT RELATIONSHIP TO SUBSCRIBER ____________

SUBSCRIBER'S EMPLOYER / RETIRED FROM ____________

EMPLOYER'S ADDRESS AND PHONE NUMBER ____________

SECONDARY INSURANCE COMPANY ____________

SUBSCRIBER NAME ____________ SUBSCRIBER DATE OF BIRTH ____________

CONTRACT NUMBER ____________ GROUP NUMBER ____________

SUBSCRIBER SOC SEC # ____________ PATIENT RELATIONSHIP TO SUBSCRIBER ____________

SUBSCRIBER'S EMPLOYER / RETIRED FROM ____________

EMPLOYER'S ADDRESS AND PHONE NUMBER ____________

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IS THIS THE RESULT OF AN AUTO ACCIDENT? CHECK ONE YES NO
IS THIS A WORKER'S COMPENSATION CLAIM? CHECK ONE YES NO

NAME OF INSURANCE COMPANY ________________________ DATE OF INJURY ____________

ADDRESS OF CLAIM OFFICE ____

NAME OF CLAIM ADJUSTOR ________________________ PHONE ________________

CLAIM NUMBER ____________________ STATE ACCIDENT OCCURRED IN ______________

ATTORNEY'S NAME ____________________________ PHONE ________________

AUTHORIZATION / RESPONSIBILITY AGREEMENT

1. 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.
2. 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.
3. 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.
4. I have been informed of the HIPAA Notice of Privacy.
5. Office visit co-pays are expected at the time of service. You are responsible for supplying us with correct insurance information for billing purposes. A delay in billing from incorrect information may cause the cost of your treatment to become your responsibility.
6. There is a $20.00 fee for the initial request of copying medical records. Thereafter: One dollar per page for the first 20 pages, fifty cents per page for pages 21 through 50, and twenty cents for pages 51 and over.
7. Our office will complete one insurance form for you at no charge. Any additional forms will require a payment of $25.00 for each form.
8. Filling of prescriptions and refills are done at the discretion of the physician.

PATIENT NAME (PRINT) ____

PATIENT SIGNATURE ____

GUARDIAN'S NAME AND SIGNATURE (if applicable) ____________________________

CHIEF COMPLAINT ____

WHEN DID THIS BEGIN? ____

WHEN WERE YOU FIRST TREATED? ____

PLEASE DESCRIBE YOUR PAIN IN DETAIL

____

____

PLEASE LIST ANY CURRENT OR PAST ILLNESSES

____

____

PLEASE LIST ANY PREVIOUS SURGERIES WITH DATES

____

____

PLEASE LIST ALL CURRENT MEDICATIONS WITH DOSE AND FREQUENCY

____

____

PLEASE LIST ALLERGIES TO MEDICATIONS AND THE REACTION THAT YOU HAVE

____

____

WHAT OTHER TREATMENTS HAVE YOU TRIED? CHECK all that apply:

PHYSICAL THERAPY ACUPUNCTURE	PAIN MANAGEMENT CHIROPRACTIC	EPIDURAL INJECTIONS
DATES ____________________	DATES ____________________	DATES ____________________
DURATION ________________	DURATION ________________	DURATION ________________

FAMILY HISTORY: MOTHER ~ LIVING? YES NO LIST ILLNESSES OR CAUSE OF DEATH ________________________

FATHER ~ LIVING? YES NO LIST ILLNESSES OR CAUSE OF DEATH ________________________

SIBLINGS ~ LIST ILLNESSES ____

WHO DO YOU LIVE WITH? ____________________________________ HOW MANY CHILDREN DO YOU HAVE? _______

ALCOHOL USE (check one) DAILY WEEKLY MONTHLY RARE NEVER OTHER _____________________________

RECREATIONAL DRUG USE (check one) DAILY WEEKLY MONTHLY RARE NEVER OTHER _____________________

DO YOU SMOKE? (check one) YES NO

HOW MANY PACKS PER DAY? ___________ HOW MANY YEARS? _____________

DID YOU EVER SMOKE? (check one) YES NO

WHEN DID YOU QUIT? __________________ HOW MANY PACKS/DAY? ___________ HOW MANY YEARS? _________

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ARE YOU CURRENTLY OR HAVE YOU HAD A PROBLEM WITH:

CONSTITUTIONAL

FEVER	Y	N
WEIGHT LOSS	Y	N
FATIGUE	Y	N
NIGHT SWEATS	Y	N

EYES

INFECTIONS	Y	N
GLAUCOMA	Y	N

EARS, NOSE, THROAT

HEARING LOSS	Y	N
EAR PAIN/INFECTIONS	Y	N
RINGING IN EARS	Y	N
NASAL DRAINAGE	Y	N
SINUS PROBLEMS	Y	N
SORE THROAT	Y	N

CARDIOVASCULAR

CHEST PAIN	Y	N
HIGH BLOOD PRESSURE	Y	N
IRREGULAR PULSE	Y	N
HEART MURMUR	Y	N
EDEMA	Y	N
HIGH CHOLESTEROL	Y	N

RESPIRATORY

ASTHMA	Y	N
EMPHYSEMA	Y	N
COPD	Y	N
SHORTNESS OF BREATH	Y	N
LUNG CANCER	Y	N
CHRONIC BRONCHITIS	Y	N

ENDOCRINE

THYROID DISEASE	Y	N
DIABETES	Y	N
HORMONE PROBLEM	Y	N

HEMATOLOGIC

BLEEDING DISORDER	Y	N
ANEMIA	Y	N

ABDOMINAL

NAUSEA/VOMITING	Y	N
ABDOMINAL PAIN	Y	N
ULCERS/GASTRITIS	Y	N
REFLUX DISEASE	Y	N
LIVER DISEASE	Y	N
CONSTIPATION	Y	N
COLON CANCER	Y	N

GENITOURINARY

INFECTIONS	Y	N
INCONTINENCE	Y	N
PROSTATE CANCER	Y	N
UTERINE CANCER	Y	N
CERVICAL CANCER	Y	N

MUSCULOSKELETAL

NECK PAIN	Y	N
ARM WEAKNESS	Y	N
BACK PAIN	Y	N
LEG WEAKNESS	Y	N
JOINT PAIN/SWELLING	Y	N
ARTHRITIS	Y	N
NUMBNESS/TINGLING	Y	N

NEUROLOGICAL

MEMORY LOSS	Y	N
SEIZURES	Y	N
DIZZINESS	Y	N
SYNCOPE (FAINTING)	Y	N
SLURRED SPEECH	Y	N
BLURRED VISION	Y	N
LOSS OF BALANCE	Y	N
FACIAL WEAKNESS	Y	N
HEADACHES	Y	N
BRAIN TUMOR	Y	N

PSYCHIATRIC

MEMORY LOSS/CONFUSION	Y	N
NERVOUSNESS	Y	N
DEPRESSION	Y	N
CHANGE IN SLEEP	Y	N

THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE ______________________________

SIGNATURE

Acknowledgement of Availability of Notice of Privacy Practices of Michigan Spine Institute

I acknowledge,

A copy of Michigan Spine Institute/CT Scanning Center Notice of Privacy Practices was made available to me at the place where I went for health care services.

The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for a copy of the Notice of Privacy Practices to take with me.

If I came in from health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment situation.

____ ____________________

PATIENT OR PATIENT REPRESENTATIVE SIGNATURE DATE

If an acknowledgement is not obtained; document below the provider's good faith efforts to obtain the acknowledgement and the reasons why the acknowledgement and the reasons why the acknowledgement was not obtained.

____

____

____

____

____

____

____

____

____ ____________________

SIGNATURE OR PERSON DOCUMENTING GOOD FAITH EFFORTS DATE

FOR WORKERS COMPENSATION AND AUTO ACCIDENT PATIENTS ONLY

<u>LIEN LETTER</u>

PATIENT: ____

DATE OF BIRTH: ____

SOCIAL SECURITY NUMBER: ____

I ACKNOWLEDGE A LIEN ON ANY MONIES I RECEIVE IN SETTLEMENT OF MY CLAIM FOR INJURIES ARISING OUT OF THE ____________________
DATE OF INJURY

____
EPISODE

FOR MEDICAL EXPENSES RENDERED TO ME BY STEVEN M. RAPP, M.D. - MICHIGAN SPINE INSTITUTE.

PATIENT SIGNATURE: ____

DATE: ____

NOTICE

Due to the constant changes in insurance, it is no longer possible to interpret each individual's policy. Although we try to stay aware of these changes, it is not possible.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

Please do not get angry at us if your insurance does not cover our services. All insurance policies have exclusions and most policies have deductibles and co-payments.

Please remember that your insurance policy **IS** between you and your insurance company, and **NOT** between the insurance company and the doctor.

____ ____________________

SIGNATURE OF INSURED OR RESPONSIBLE PARTY DATE