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SPINE&PAIN
REAL PEOPLE. REAL RELIEF. SINCE 1999

Dear Patient,

Thank you for choosing Michigan Spine & Pain for your healthcare needs. It is our desire to provide you with the best healthcare available. We look forward to assisting in your recovery from injury and/or pain in order to get you back to your regular activities quickly and safely.

Due to the amount of time that our providers may need to spend with you at your initial appointment we ask that you arrive 15 minutes prior to your scheduled appointment time. This will allow our staff to enter all of your information into the computer and obtain any information that may still be needed. Due to the complexity of some of our patients you may experience a longer wait time. Please come prepared and we will make every effort to maintain our schedule.

At your initial appointment, the provider will take a complete history. Please complete the attached new patient packet in its entirety. If you need additional space you may use an additional sheet of paper. This will ensure the provider has a complete and accurate history. Please bring your driver's license and insurance cards to your appointment. All Copayments and Deductibles will be collected at the time of service.

Follow up visits may be scheduled with a nurse practitioner or physician's assistant who works closely with your physicians. They are a very important part of our team and will make every effort to help you manage your pain.

If you have any questions or concerns, please contact our office at any time for assistance or visit our website at michiganspineandpain.com for more detailed information regarding treatment options.

Sincerely,

The Michigan Spine & Pain Staff

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AUTHORIZATION AND CONSENT TO OBTAIN AND RELEASE INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize my Medical Records to be released **to/from** Michigan Spine & Pain. This information to be released is to be used only for the following authorized purpose:

- **Planning and Management of Medical Care**
- **Payment of Services by a Third Party Payor**
- **Purposes of Litigation with Michigan Spine and Pain Counsel**

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
- I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- *This Release of Information will remain in effect until terminated by me in writing.* I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Please list responsible parties who may receive your health information. (Spouse, mother, child, Nurse Case Manager, etc.) Please provide name and relationship below:

If unable to reach me:
[ ] you may leave a detailed message regarding appointment reminders, test results, general messages
[ ] please leave a message asking me to return your call.
[ ] other _____

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature Date

***PLEASE READ** Fee Information*:* **Michigan Spine and Pain** contracts with DataFile Technologies to copy and provide all medical records requested from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy. DataFile Technologies: 816-437-9134 www.datafiletechnologies.com

Revised 05/11/2017

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Michigan Spine and Pain Financial Policy

It is important for you to know what your insurance policy covers. Please be aware that not all medical services are covered benefits under all insurance contracts. As your provider, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance company. If you have any questions about your insurance coverage please contact your insurance company directly.

Michigan Spine & Pain employs Registered Medical Coders and Certified Professional Coders to bill your insurance as a courtesy to you. Providing us with accurate information at the time of service will result in timely filing of your claims. Any changes in coverage, address, or insurance company contract information should be reported back to the office immediately.

It is your responsibility to check with your insurance company to ensure that Michigan Spine and Pain providers participate with your insurance network. If Michigan Spine and Pain is not in your insurance company's network you may incur higher patient responsibility amounts. Our office participates with the following insurance companies:

- Blue Care Network
- Blue Cross and Blue Shield
- Cigna **– Dr. Bleiberg only**
- First Health – **Dr. Ruiz only**
- HCAP
- Medicare
- Medicaid
- Mclaren
- Physicians Care – **Dr. Bleiberg only**
- Priority Health
- Group Enterprise
- PACE

If you do not have insurance, you will be expected to pay for your appointment in full at the time of your appointment.

In order to comply with your insurance company requirements, all deductibles and copayments are due at the time of service.

You are responsible for payment of any and all treatments that may not be covered by your insurance.

Failure to pay any amount due, including past due balances, will result in your appointment being rescheduled.

Patients will be charged a fee of $50.00 per check for checks returned to our office for non-sufficient funds.

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Michigan Spine and Pain Financial Policy, Continued

It is your responsibility to provide Michigan Spine and Pain with ALL accurate, complete and up to date information regarding any and all insurance policies that you have in place prior to each visit. Failure to provide all of this information in its entirety will result in the patient being personally responsible for any and all charges not covered or paid for by an insurance company. Even if Michigan Spine and Pain participates with an insurance policy that you have at the time of service/visit, failure to provide this information will mean that Michigan Spine and Pain is not bound by any contractual agreement with your insurance carrier and the patient will be fully responsible for all charges.

Patients will be charged a fee of $100.50 for failure to cancel their appointment within 24 hours prior to the appointment and/or not showing for their appointment. Patients may be discharged from the practice at the provider's discretion.

If you undergo urine toxicology testing, you will receive an invoice from Michigan Spine and Pain for the test. In addition, many of our lab results are also sent to a confirmatory lab for additional information on quantitative results of the specimen. If your test is sent to a confirmatory lab, you will receive a separate bill from the lab company for their services.

If your account is over 120 days past due, your account will be referred to our outside collection agency. This may include listing with the credit bureau. Your account will be reviewed for possible discharge from care.

Patients agree that if they have a credit balance after paying for a service, Michigan Spine and Pain can apply this credit to any outstanding balance on their account. Patients will be refunded any amounts paid in excess upon request after all outstanding amounts have been credited.

In all instances, our office will work with patients having difficulties paying for their care. We understand that extenuating circumstances occur with injuries and accidents and we would like to help you navigate the issues that arise. If you would like to speak with someone regarding payments, please contact our Patient Accounts Department, at 989-772-1609 x21802

I have read and understand the above Financial Policy. I hereby authorize Michigan Spine and pain to file claims on my behalf and for payment of insurance benefits be made directly to Michigan Spine & Pain for those services.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

Revised 05/11/2017

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NEW PATIENT INFORMATION

First: _____ Middle Initial: _____ Last: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security No.: _____/_____/_____

Home Phone No.: ( ) _____ Alternative Phone No: ( ) _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Height: _____ Weight: _____ Sex: _____ Right or Left Handed?: _____

Emergency Contact Person: _____ Relationship to you: _____

Home Phone No.: ( ) _____ Alternative Phone No.: ( ) _____

Family Physician / Primary Care Provider: _____

Other physicians you have seen in the past year: _____

INSURANCE INFORMATION

☐ **No Insurance, I will privately pay for my treatment.**

Primary Insurance: _____

Name of Subscriber: _____ Date of Birth of Subscriber: _____/_____/_____

Subscriber's Social Security No.: _____

Policy No.: _____ Group No.: _____

Secondary Insurance: _____

Name of Subscriber: _____ Date of Birth of Subscriber: _____/_____/_____

Subscriber's Social Security No.: _____

Policy No.: _____ Group No.: _____

☐ **Workers' Comp** ☐ **Auto** **Date of Accident / Incident / Injury:** _____

Claim No: _____

Name of Adjuster: _____ Phone No.: ( ) _____

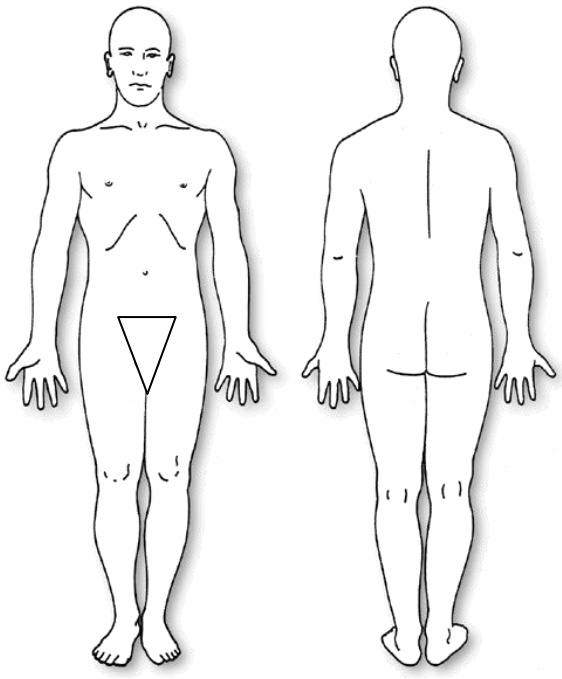
Insurance Billing Address: _____

New Patient Information

_____

Date of Injury/Onset of Pain_____

Where is your pain located? On the diagrams below, please shade in the areas where your pain is located. P = Pain T = Tingling N = Numbness



On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain ***right now***?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										*worst possible pain*

How would you rate your pain, on ***average***, during this ***last week***?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										*worst possible pain*

 Patient's Initials: _____

New Patient Information

MEDICATIONS – PLEASE FILL OUT COMPLETELY AND ACCURATELY PLEASE REFER TO YOUR MEDICATION BOTTLE(S) IF ADDITIONAL SPACE IS NEEDED – PLEASE USE ADDITIONAL SHEET			
Name of Medication	**Dose (mg)**	**How Often**	**How Many Pills Per Day**

PAST MEDICAL HISTORY

Please check any of the following health problems with which you have been diagnosed:

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clots
☐ Cancer of _____
☐ Cataracts
☐ Chemical Dependency
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Emphysema / COPD
☐ Epilepsy / Seizures
☐ Gastric Reflux Disease
☐ Glaucoma
☐ Gout
☐ Hepatitis
☐ HIV / AIDS
☐ High Cholesterol
☐ Hypertension
☐ Irregular Heartbeat
☐ Kidney Stones
☐ Migraine Headaches
☐ Osteoporosis
☐ Pacemaker
☐ Pneumonia
☐ Prostate Problems
☐ Shingles
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Disease
☐ Tuberculosis
☐ Vascular Disease
☐ History of Pain or,
☐ Injury in Same Area
☐ Other: _____

Medication Allergies: _____

_____

Other Allergies: _____

PAST SURGICAL HISTORY

Type of Surgery	Date

 Patient's Initials: _____

New Patient Information

Please check the appropriate words that best describe your pain:

☐Aching	☐Severe	☐Constant	☐Tingling
☐Radiating	☐Unbearable	☐Heavy	☐Numbing
☐Intense	☐Dull	☐Stinging	☐Sharp
☐Transient	☐Hot	☐Burning	☐Tight
☐Shooting	☐Sore	☐Annoying	☐Excruciating
☐Cramping	☐Cold	☐Brief	☐Stabbing

FAMILY HISTORY

Are there any diseases that run in your family? ☐ Yes ☐ No If yes, please list below:

Are there any close family members who are disabled? ☐ Yes ☐ No If yes, please list below:

Father: ☐ Alive ☐ Deceased Medical Problems: _____

Mother: ☐ Alive ☐ Deceased Medical Problems: _____

Grandparents: ☐ Alive ☐ Deceased Medical Problems: _____

Your Children: ☐ Alive ☐ Deceased Medical Problems: _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No How Many? _____

Who lives in your home with you? _____

Do you smoke cigarettes? ☐ Yes ☐ No How many packs per day? _____ Years? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____ Years? _____

Have you used street drugs? ☐ Yes ☐ No What kind? _____

Do you currently use drugs? ☐ Yes ☐ No What kind? _____

Education: ☐ High School Graduate ☐ College Graduate ☐ GED Other: _____

Grade Completed (Circle): 6 7 8 9 10 11 12

Hobbies/Activities affected by pain: _____

 Patient's Initials: _____

New Patient Information

WORK HISTORY

Are you currently working? ☐ Yes ☐ No

IF No: ☐ Retired ☐ Homemaker ☐ Disability ☐ Unemployed

PLEASE COMPLETE THE FOLLOWING USING YOUR MOST RECENT EMPLOYER – EVEN IF YOU ARE NOT CURRENTLY WORKING

Date Last Worked: _____ Date of Hire: _____

Place of Employment: _____

Job Title: _____ Are you currently under work restrictions: ☐ Yes ☐ No

If yes, who placed you on work restrictions?: _____

If yes, please list your restrictions: _____

Do you perform repetitive activity? : ☐ Yes ☐ No

If yes, please list these repetitive activities: _____

Maximum number of pounds lifted: _____ Parts processed per hour: _____

Hours worked per day: _____ Days worked per week: _____ Shift: _____

Describe your job in detail_____

Have you ever been injured at work? ☐ Yes ☐ No If yes, please explain:

Type of injury: _____ Date: _____

How many days have you lost from work due to this injury/illness? ☐ None ☐ _____ Days

New Patient Information Acknowledgment

I have answered all of the questions in full and to the best of my ability. I certify the information I have provided is true. I do understand any false information or information left out could affect my medical care and rehabilitation. I promise to notify the office of Michigan Spine & Pain immediately should there be any changes or new information. If female, I am aware that I may be placed on medications or undergo procedures that could be potentially harmful to an unborn baby. If female, I agree to notify the office of Michigan Spine & Pain immediately if I suspect I may be pregnant. I hereby authorize and consent Michigan Spine & Pain to furnish the requested treatment and/or diagnostic services.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

FUNCTION	Please check (✔) the level you are able to complete the following functions
SIT	☐Able to Sit ☐ Able to Sit with Equipment Sit Duration? _____ Minutes / Hours ☐Unable to Sit
STAND	☐Able to Stand ☐Able to Stand with Assistance Stand Duration? _____ Minutes / Hours ☐Unable to Stand
WALK	☐Walks Independently without Assistance or Equipment ☐Walks with Some Help/Assist Device Walk Duration? _____ Minutes / Hours / Blocks / Miles ☐Unable to Walk
LIFT	☐Able to Lift 50+ lbs ☐ Able to Lift 25 – 50 lbs ☐ Able to Lift 10 – 25 lbs ☐Able to Lift < 10 lbs ☐Unable to Lift
PUSH / PULL	☐Able to Push/Pull 50+ lbs ☐ Able to Push/Pull 25 – 50 lbs ☐Able to Push/Pull 10 – 25 lbs ☐Able to Push/Pull < 10 lbs ☐Unable to Push/Pull
BATHES	☐Bathes Self Independently ☐Bathes Self with Some Help ☐Unable to Bathe Self
BEND / TWIST	☐Able to Bend/Twist without Difficulty ☐Able to Bend/Twist with Pain (Direction) _____ ☐Unable to Bend/Twist
CLEAN HOUSE	☐Able to Clean House ☐Able to Clean House with Assistance ☐Unable to Clean House
COOK	☐Able to Cook ☐Able to Cook with Assistance ☐Unable to Cook
DRESS SELF	☐Able to Dress Self ☐Able to Dress Self with Assistance ☐Unable to Dress Self
DRIVE	☐Able to Drive ☐Unable to Drive
FEEDS SELF	☐Able to Feed Self ☐Able to Feed Self with Assistance ☐Unable to Feed Self
GROOM	☐Able to Groom Self at Head/Face Level (Brush Teeth/Comb Hair) ☐Able to Groom Self at Head/Face Level (Brush Teeth/Comb Hair) with Assistance ☐Unable to Groom Self at Head/Face Level (Brush Teeth/Comb Hair)
DO LAUNDRY	☐Able to Do Laundry ☐Unable to Do Laundry
LAY ON BACK	☐Able to Lay on Back ☐Able to Lay on Back with Assistance or for a Short Period of Time ☐Unable to Lay on Back
LAY ON STOMACH	☐Able to Lay on Stomach ☐Able to Lay on Stomach with Assistance or for a Short Period of Time ☐Unable to Lay on Stomach
SEXUAL ACTIVITY	☐Able to Engage in Sexual Activity ☐Unable to Engage in Sexual Activity
TRANSFER SELF	☐Able to Transfer Self ☐Able to Transfer Self with Assistance ☐Unable to Transfer Self
VACUUM	☐Able to Vacuum ☐Unable to Vacuum
WORK	☐Currently Working ☐Currently Not Working ☐Able to Work ☐Unable to Work ☐Able to Work with Restrictions ☐Currently Working with Restrictions ☐Currently Working without Restrictions