CHECK LIST FOR APPOINTMENT:

As a new patient to our practice, we would like to welcome you and provide you with important information. Please review the items needed for your appointment to ensure that your experience is efficient and satisfactory.

Your appointment date:_____ time:_____

Doctor:_____ Location:_____

Print off and complete the patient forms associated with the physician you will be seeing. If you are reading this notice, you are here (please print the entire packet). If you have completed this packet, please bring with you and arrive 10-15 min prior to your first appointment. **If you do not have a computer with printing abilities then you MUST arrive to the office 45 minutes early to fill out all necessary paperwork.**

In addition to the New Patient Packet you must also bring the following:

- ✓ Picture ID (drivers license or state ID)
- ✓ Insurance Cards. If you have an HMO, you MUST bring a referral with you if required (most office will no longer fax referrals). You will NOT be seen without a referral.
- ✓ Your Copay and Deductible (if applicable). Our financial policy is located on our website under the "Patient Forms" tab.
- ✓ Work-Related or Auto-Related injuries require a written letter of open claim. This letter must include the claim #, billing address, name and phone number of contact person (case manager).
- ✓ If you have underwent diagnostic testing (ie., Xrays, MRI, CT, EMG, etc.) prior to your appointment then you must bring the actual images to your appointment. Radiology Reports alone are not acceptable. Please bring the images via hard films/hard copy or CD of images.
- ✓ List of medications, supplements, allergies.
- ✓ Primary Care Doctor, Referring Doctor, and Cardiologist (if applicable) address, phone and fax numbers. This will allow us to coordinate care if appropriate.
- ✓ Pharmacy name, address, phone number and fax number.
- ✓ Email Address, so that you can register for an access your electronic medical record.
- ✓ If there is a language barrier, you will need to bring a translator that is 18 years of age or older that reads, writes and understands the English Language.
- ✓ If you are a minor, you will need to have an adult/guardian with you at all times.

Due to the nature and complexity of some orthopedic conditions, an extended amount of time (2-3 hours) should be allotted for your initial evaluation. Please plan accordingly. We also advise that you read the attached sheets which include basic policies of our office. You will be asked to sign these forms. If there any are any questions they can be addressed at the office.

Driving directions to all of our office are noted on the Locations Tab of our website www.miortho.com

We look forward to providing care for you!

PATIENT INFORMATION (PLEASE PRINT)

Appointment:	I am here to see:				
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single Married Divorced Separated Widowed
Street Address:	City/State/Zip:				Home phone #:
Emergency Contact:	Relationship: ❑ Spouse ❑ Daughter ❑ Son ❑ Other:				Contact #: ( )
Social Security no.:	Birth date:	Age:	Sex: ❑ M ❑ F		Cell phone #:
Email Address:	Height:		Weight:		

❑ Work full time ❑ work part time ❑ homemaker ❑ unemployed ❑ disabled (what reason)_____

Where do you live? ❑ Home ❑ Assisted Living ❑ Nursing Home ❑ Other_____

Occupation:	Employer (if student, list school):	Employer phone #: ( )
How did you hear about us? ❑ doctor ❑ hospital ❑ advertising/radio/tv ❑ friend/family:		

PHYSICIAN & PHARMACY INFORMATION

Referring Physician:	Address:	Phone#: Fax#:
Family Doctor:	Address:	Phone#: Fax#:
Cardiologist (if applicable):	Address:	Phone#: Fax#:
Pharmacy Name:	Location:	Phone#: Fax#:

INSURANCE INFORMATION

Name of primary insurance:				Employer:
Subscribers name:	Subscriber's SS no:	Birthdate:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Name of secondary insurance:				Employer:
Subscribers name:	Subscriber's SS no:	Birthdate:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Are you seeing the doctor due to an injury?	❑ Yes ❑ No	Date of Injury:		❑ on the job ❑ auto accident ❑ sports ❑ other
Were you treated in the Emergency Room	❑ Yes ❑ No	Which One?		
Do you have an open claim with *IF YES, COMPLETE FORM*	Auto? ❑ Yes ❑ No	Workers Comp? ❑ Yes ❑ No		Other Liability? ❑ Yes ❑ No

PLEASE PRESENT YOUR INSURANCE CARDS AND IDENTIFICATION TO THE RECEPTIONIST. COPAYS & CO-INSURANCE ARE COLLECTED PRIOR TO SEEING THE PHYSICIAN. WE ACCEPT CASH, CHECK, VISA AND MASTERCARD. PLEASE MAKE CHECK'S PAYABLE TO DR. Rakesh Ramakrishnan. THANK-YOU.

ACCIDENT / INJURY FORM - (PLEASE PRINT)

Patient's last name: First: Middle:	Birth date:	Age:	❑ M ❑ F

Seeing the doctor due to an injury? ❑ Yes ❑ No	Were you treated in the Emergency Room? ❑ Yes ❑ No
Date of Injury:	Which One?

❑ Injury NOT AUTO OR WORK ❑ accident or ❑ sports related Where & How did it happen?	Height:	Weight:

❑ Injury at work
From a ❑ lift ❑ twist ❑ fall ❑ bend ❑ pull ❑ reach

❑ Auto accident: I was a ❑ Passenger ❑ Driver Were you wearing your seatbelt? ❑ Yes ❑ No

Body part involved?	❑ Right ❑ Left

Have you had surgery for a problem in the same area either recently or in the past? ❑ Yes ❑ No

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

Are you currently receiving or do you plan to apply for:	Disability ❑ Yes ❑ No Workers' comp ❑ Yes ❑ No Unemployment ❑ Yes ❑ No

Last date worked your regular job?	Have you had a problem like this before? ❑ Yes ❑ No If yes, when?

AUTO / WORKERS COMP / OTHER CARRIER

Do you have an open claim? ***MUST COMPLETE BELOW!***	Auto? ❑ Yes ❑ No	Workers Comp? ❑ Yes ❑ No	Other Liability? ❑ Yes ❑ No

Insured Last Name: First: Middle:	Claim #: Policy#:

Patient's relationship to insured:	❑ Self	❑ Spouse	❑ Child	❑ Other

Carrier Name:	Address:	Phone#: Fax#:
Adjustor Name:	Address:	Phone#: Fax#:
Case Manager Name:	Address:	Phone#: Fax#:

Do you have coordination of benefits? ❑ Yes ❑ No Is your regular health insurance primary? ❑ Yes ❑ No

Please note that this office charges a nominal fee for the completion of forms and copying of medical records. The fee depends on the type of form and/or # of pages copied. Due to the large volume of requests we receive and circumstances such as transcription service turn-around it could take up to a week or longer to complete these requests, however, we make every attempt to complete them sooner. A signed authorization to release is required in many instances and pre-payment is required. If you need more information, please see one of our associates. Thank-you.

PATIENT NAME: _____ **DOB:** _____

DR. RAMAKRISHNAN'S PAIN MEDICATION POLICY

No prescription Narcotics will be dispensed unless you have been evaluated, deemed a surgical candidate, and surgery has been scheduled.

Refills must be called in to the refill line within 48 hours of running out.

If you have had surgery by Dr. Ramakrishnan, pain medication will be prescribed for 3 months after surgery. Your primary care physician is responsible for any pain management after that point.

When receiving pain medications by Dr. Ramakrishnan, you must disclose any other sources from which you are receiving pain medications. Random pharmacy database checks will be made, and if you are receiving pain medications from multiple doctors, your pain medication will be terminated.

Your medication is your responsibility; if lost or stolen, it will not be refilled until the appropriate date.

DR. RAMAKRISHNAN'S DISABILITY POLICY

No work notes will be filled out unless you have been evaluated, deemed a surgical candidate, and surgery has been scheduled. NO PERMANENT DISABILITY WILL BE GIVEN TO ANY PATIENT.

DR. RAMAKRISHNAN'S INSTRUCTIONS FOLLOWING AN MRI OR CT SCAN

After your MRI or CT scan has been completed, you will be given a disc or film. If the technician does not give this to you – **you must request and bring the disc or film to your follow-up visit**. The disc or film **MUST** be presented to Dr. Ramakrishnan at **EVERY** visit for follow up care. This information is necessary in order for us to provide the best care possible and your follow up visit may not be completed without it.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

STAFF WITNESS: _____ **DATE:** _____

PATIENT NAME:_____ **DOB**:_____

AUTHORIZATION FOR TREATMENT & PAYMENT

The above information is true to the best of my knowledge. I hereby authorize treatment of the above named person and acknowledge to that I am able to read, write and understand English and if not, I have brought an adult with me who is able to interpret on my behalf. I authorize my doctor's billing pc, Michigan Orthopedic Specialists and it's agents to furnish information to my current or future insurance carrier(s) any information needed for the purposes of securing payment for services provide and assign all payment for services provided to the physician listed above all. I u n d e r s t a n d that I am financially responsible for any amounts not covered by my insurance and any co-pay, co-insurance, balance or deductible will be collected before I am treated by the physician. Any amounts owing after my insurance has paid their portion will be remitted p r o m p t l y upon receipt of a statement. It is my responsibility to obtain any authorization required prior to seeing the specialist and I may not be seen without it if required due to insurance.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

ACKOWLEDGEMENT OF FINANCIAL POLICY

By signing below I acknowledge that I have received a copy of this office's Financial Policy which is also available on the website for review at any time.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form,

which is also available on the website for review at any time.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

We will speak to your emergency contact listed on your registration form (list more than one name if you have adult children who participate in your care), or spouse listed unless you provide a request for restriction for privacy reasons. Ask a staff member to note the file regarding your restriction against spouse or adult children and make a note below. All others will require a signed authorization.

[ ] Do not speak to my emergency contact listed or spouse listed, unless it is an emergency.

[ ] I have a case worker involved in my care (WC/Auto). Please speak to them when necessary so my benefits are not

delayed. I have listed their name, phone # and fax# here: _____.

For office use only:

On date below, I presented this Acknowledgement of Receipt of Notice of Privacy form to the above named patient and/or their guardian and the patient refused to provide signature when requested.

Office Staff Signature:_____ DATE:_____

PATIENT NAME:_____ **DOB**:_____

REQUEST FOR PATIENT EMR PHOTOGRAPH

Our physician requests that each patient's photograph is attached to the file. Our staff requests this at check in. This is to help ensure security of your account, to mitigate the possibility of an entry into the wrong chart, and to help prevent medical or identity fraud. Any patient who is refusing a photograph is asked to state the reason why and sign and date here. If a photo is refused, a photo of your signature and reason for refusal will be used in its place for the physician's reference. Your cooperation is appreciated.

[ ] Yes, I will smile for the camera.

[ ] No, I AM REFUSING TO HAVE MY PHOTOGRAPH TAKEN FOR THE FOLLOWING REASON:

_____

_____

Patient Signature (or guardian):

_____

Date: _____

PATIENT PORTAL REGISTRATION

[ ] I provided my email when appointment made and completed the registration online. **I will not send emergent messages through the patient portal and acknowledge that messages are checked by a staff member of the physician**.

[ ] if not registered, reason: _____

Please note, that using our patient portal is the only available method we have to ensure secure, electronic communication at this time. We highly encourage that all patients wishing to communicate electronically with the practice do so through registration of the patient portal. Unfortunately, the limitations on our EMR's patient portal does not allow for attachment of documents.

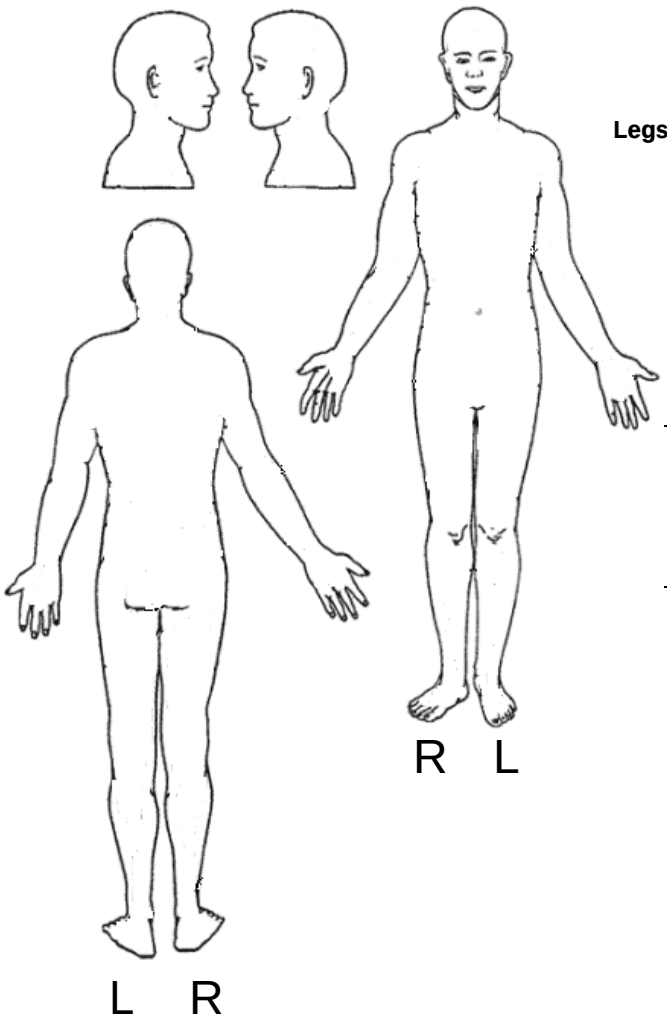
CONSENT TO COMMUNICATE VIA EMAIL (non-encrypted). The security of regular email use and re-disclosure by a third party cannot be guaranteed by Michigan Orthopedic Specialists, however, we realize that many patients may choose this method of communication of their protected health or claim information for the convenience, or to expedite exchange of information with themselves, case managers, attorney or other third party involved in their claim for care and treatment with the physician. ***As required under HIPAA, we will still follow the required guidelines for obtaining consent to release information when required; however, this will allow us to send that information via email when signed below (see privacy notice)***. Please sign below to consent to allow Michigan Orthopedic Specialists to send your health information when requested by you or designated party via email.

Patient Signature (or guardian):_____ Date: _____

Effective 1/1/16

Dr. Ramakrishnan's Pain Questionnaire – CONTINUED (PLEASE PRINT)					
Patient's last name:	First:	Middle:	Birth date:	Age:	❑ M❑ F
Referred by (Name):					
Primary Care Physician (Name):					

Using the symbols below, mark the area on your body where you feel the described sensations.
>>>>> Numbness **XXXXX** Burning **00000** Pins and Needles ●●●●● Aching/Pain



For the appropriate body part
Please circle the number that corresponds to your **average** pain over the last few days.

Neck	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible
Arms	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible
Back	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible
Legs/Buttocks	No Pain	0 _ 1 _ 2 _ 3 _ 4 _ 5 _ 6 _ 7 _ 8 _ 9 _ 10	Worst Pain Possible

1. Time of Symptoms _____years_____months
2. What were you doing when it started? _____
3. Have you had this problem before? Yes No When?_____
4. Have you had any **new** BOWELOR BLADDER incontinence?
5. Do you have Balance or Coordination problems?
6. Missed work because of this problem? Yes No
7. Were your current problems related to a work or motor vehicle accident? Yes No
8. Does it feel **BETTER** when you are:

YES	YES
Standing	Walking
Sitting	Exercising
Lying down	Other:

9. Does it feel **WORSE** when you are:

YES	YES
Coughing/sneezing	Bending
Sleeping	Lifting
Standing	Walking
Max time	Max Distance

All unmarked answers are negative and the above has been reviewed by Dr. Ramakrishnan (initialed here)

DR RAMAKRISHNAN'S QUESTIONNAIRE – CONTINUED (PLEASE PRINT)

Patient's last name:	First:	Middle:	Birth date:	Age:	❑ M❑ F

What kind of TREATMENT/ WORKUP have you had for THIS **CURRENT EPISODE of pain**?

	YES		
Bed rest		How many days?	
Medications		What kinds?	
Physical therapy		How many weeks?	Where?
Chiropractor		Name:	
Pain Clinic Epidurals/facet block		Where: Type and # of injections:	
MRI:		When:	Where:
CT Scan:		When:	Where:
EMG		When:	Where:
Other sturdies			

Spine Surgeries:

When	Where	Surgeon	Type

Place an "X" if you NOW have or RECENTLY had:

YES	YES	YES
Fever/Chills	Fever/Chills	Fever/Chills
Significant Weight Loss How much?	Incontinence – stool	Incontinence – urine
Excess bleeding	Infection	

MEDICATION RECORD – Dr. Rakesh Ramakrishnan

Patient Name:_____**DOB**:_____

Pharmacy:_____**Phone:**_____**Fax:**_____

Address:_____

ALLERGIES/REACTIONS

Allergic To:	Reaction:

CURRENT MEDICATION
PLEASE INCLUDE SUPPLEMENTS AND VITAMINS

DATE	MEDICATION	DOSAGE	QTY

Patient Signature:_____Date_____

MICHIGAN ORTHOPEDIC SPECIALISTS

ERIC T. SILBERG, MD, PC • JOSEPH C. FINCH, DO, PC • MARC J. MILIA MD, PC
NILESH M. PATEL MD, PC • ALFRED M. FAULKNER, DO, PC
HUSSEIN A. SAAD MD, PC • RAKESH RAMAKRISHNAN, DO, PC

OUR PRACTICE FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about this policy, please discuss them with a representative from our office. We are dedicated to providing the best possible care and the highest level of service and regard your complete understanding of our financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or with your health insurance carrier, full payment is due at the time of service. For your convenience, we accept CASH, CHECKS, VISA & MASTERCARD.

Medicare Patients:

We are participating providers of Medicare. We will be collecting your 20% Medicare coinsurance and/or deductible (if applicable) at the time of your visit, **UNLESS** your secondary carrier is automatically "crossed-over" by Medicare. In that case, if your secondary carrier's reimbursement does not cover the co-insurance in full, you will be billed for the balance. Any amounts billed are due upon receipt.

Managed Care & Other Insurance Patients:

REFERRALS:

We have made prior arrangements with many insurers and other health plans to accept assignment of benefits and with whom we are participating providers. **The following requirements will need to be adhered to**:

- If a ***referral form*** or ***referral authorization*** is required, you must present it to the receptionist at the time of your initial appointment. If you are scheduled for follow up visits, **it is your responsibility to make sure that your ongoing referral is valid.**
- If you choose to use your benefits "out of network" (without a referral from your PCP), you will be responsible for any associated out of pocket expenses, which will be due at time of service. Questions can be directed to the Billing Office.
- If you do not have out of network benefits and you opt to be seen without a referral authorization, you will be required to pay for the services in full. An estimated portion of your visit must be paid prior to being seen.

CO-PAYMENTS:

- ***Please be prepared to pay your co-payment/coinsurance at the time of your visit.***

DEDUCTIBLES:

- ***If you have an unmet deductible, please be prepared to pay your portion at the time of your visit.***

***If you have an open balance or copayment due, you will be expected to resolve it with our billing department prior to being seen*. Our physician's and staff are unable to make exceptions to this, or any other policy adopted by our management.**

WORKERS COMPENSATION & AUTO CLAIMS:

If you have a claim, prior to scheduling an appointment, we must receive a written letter from your adjustor showing that there is an open claim, and it must contain the physician's name you are scheduling with, the adjustors name and phone number, billing address and must state that the claim is open and billable.

Other Fees:

FORMS:

If you require a note for work or school that indicates restrictions, be sure to talk to the doctor about this at the time of the visit. Our office will provide you with a note from our office that indicates any restrictions reflected in the physician's notes. If your job, school or disability carrier requires a specific form to be completed, there is a nominal charge for this, starting at $10 and goes up depending on the length of the form.

MEDICAL RECORDS:

There is a charge for medical records, in accordance with state guidelines and fees vary depending on how many pages are printed. We must have a signed authorization on file prior to processing the request and payment must be received prior to their release. An authorization form may be obtained from our office or website and faxed to the medical records department at 313-277-2483.

MISSED APPOINTMENTS:

Patients must give advance notice if they are not going to make their appointment, with the reason for their cancellation. **For any patient who has been a no-show twice, there will be a $50 missed appointment charge that must be paid prior to being rescheduled.** This charge is not payable by insurance and will not be billed to your insurance carrier. Our scheduler's must have confirmation of payment prior to scheduling your appointment.

A NOTE ABOUT OUR FEES:

You may have been quoted a fee for your consultation or office visit. Please be aware that until the doctor examines you and discusses your medical needs, we cannot determine prior to your visit whether or not you will require any special diagnostic or therapeutic care during your visit. If you do require a diagnostic or therapeutic procedure, this service will be billed in addition to the fee for the office visit. Please feel free to ask questions about the care your doctor recommends.

It is the responsibility of the patient to know the terms of his or her insurance coverage. Please call your carrier if you have any questions about your benefits. Deductible or co-insurance amounts withheld from our payment are the responsibility of the patient. If you have any questions about this, please speak to our Billing Office. We must have a copy of your current insurance card(s) on file at all times you are actively being treated or have an active and unpaid claim in our office.

If we are denied payment due to lapse of coverage, misrepresented information provided to us at any time by you or your insurance carrier, failure to notify us of a change in your insurance information, or your failure to follow the rules of your insurance contract or return requested information to support your claim, you will be responsible for our regular fee.

This notice is made available to all new patients upon their first visit to our office and can be viewed on our website at any time.

Questions or concerns should be put in writing and sent by United States Postal Service to Board Of Directors, Michigan Orthopedic Specialists, 21031 Michigan Avenue, Dearborn, MI 48124.