Account Numbers:		BPW_____
JPW_____	TDM_____	MDP_____
JMW_____	PJW_____	GVS_____

WELCOME TO

Beverly Hills Orthopaedic Surgery

Patient Information

Date_____

Patient_____

Address_____

_____

City State Zip

Email_____

Sex: ☐ M ☐ F Age_____ Birth date____/____/____

Are You: ☐ Left-Handed ☐ Right-Handed

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address

Employer Phone_____

Spouse's Name_____

Birth date_____

Occupation_____

Spouse's Employer_____

Race: ☐ White ☐ African American ☐ Caucasian ☐ Other_____

Ethnicity: ☐ Filipino ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino

Language: ☐ English ☐ Spanish ☐ Arabic ☐ Albanian ☐ Other_____

Whom may we thank for referring you? Dr._____

Phone#_____Address_____

☐ Pt. refused

Phone Information

Home Number:_____

Work Number:_____ Ext._____

Best time to reach you:_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Home Phone_____

Work Phone_____

Job or Related Insurance Information

Were you injured at work? ☐ Yes ☐ No

If yes, name of Comp Carrier_____

Date of Injury____/____/____

Contact Person_____

Phone#_____

Were you injured in an auto accident? ☐ Yes ☐ No

Date of Injury____/____/____

Agent Name_____Phone#_____

Claim Number_____

Insurance Information

Name of **Primary** Insurance_____

Policy Holder Name_____

Policy Holder Birth date____/____/____

Contract or Policy Number_____

Group Number_____Service Codes_____

Name of **Secondary** Insurance_____

Policy Holder Name_____

Policy Holder Birth date____/____/____

Contract or Policy Number_____

Group Number_____Service Codes_____

Authorizations

Assignment & Release

The undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature/Relationship Date

Beverly Hills Orthopaedic Surgery

Jerome P. Wiater, M.D., P.C.
Orthopaedic Surgery

J. Michael Wiater, M.D., P.C.
Orthopaedic Surgery
Shoulder and Elbow Surgery
Sports Medicine

Patrick J. Wiater, M.D., P.C.
Orthopaedic Surgery
Trauma and Reconstructive Surgery

Brett P. Wiater, M.D., P.C.
Orthopaedic Surgery
Shoulder and Elbow Surgery
Hand Surgery

Thomas D. Magnell, M.D., P.C.
Michael D. Pochron, M.D., P.C.
Orthopaedic and Reconstructive Hand Surgery
Gregory V. Sobol, M.D., P.C.
Orthopaedic and Reconstructive Hand and Upper Extremity Surgery

AUTHORIZATION FOR THE RELEASE OF PATIENT MEDICAL RECORDS

I authorize release of medical information contained in my patient records, including alcohol and/or drug abuse records, psychiatric treatment, and any information regarding communicable diseases and infections as defined by the Michigan Department of Public Health rule which can contain venereal diseases, tuberculosis, HIV, AIDS, or ARC to the individual or organization listed below.

Release to:

Name _____

Address _____

_____

_____

Phone Number: _____( ) _____ - _____

Fax Number: _____( ) _____ - _____

Physician Name _____

Patient Name *(please print)* _____

Patient Signature _____

Date_____

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As a patient of Beverly Hills Orthopedics, I authorize the physicians to examine, diagnose and render all treatment as they deem necessary. If care is needed for my minor / disabled child or relative custodial to me, I authorize the same treatment for them also.

I have requested that Beverly Hills Orthopedics bill my insurance company for covered services provided by the physicians here on my behalf. I authorize payment directly to them. I understand that it is still my responsibility to make sure that the bill is paid in a reasonable time. If, for any reason, any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

I understand that I am financially responsible for all charges not covered by this assignment.

I further understand that it is my responsibility to obtain referrals from my PCP if I have an HMO plan prior to my visits and agree to pay in full for the office visit, in the event this is not obtained prior to my seeing the physician.

I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

In order to process a claim for benefits, I authorize the physicians and their representatives at Beverly Hills Orthopedics to release to my insurance company any information regarding my medical history, treatment, symptoms, examination results or diagnosis necessary for payment of the claim. If this is a workers compensation claim, I authorize release of information to this carrier also, whether written or oral, for payment of this claim.

If I am not insured, I assume full responsibility for all charges for services rendered and agree to pay in full at the time of visit. I understand that it is not the policy of Beverly Hills Orthopedics to bill me for services. Payment is due in full when services are rendered.

SIGNED _____ DATE_____

Beverly Hills Orthopaedic Surgery

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Orthopaedic and Reconstructive Hand and Upper Extremity Surgery

Dear Patient:

We want to provide you with some information regarding our consulting agreements with orthopaedic companies.

Some of the orthopaedic surgeons in this office have been active with research and development of new implants and improved surgical instruments and techniques. As part of this work, they have worked under contract with orthopaedic companies, providing consulting services on new products and input on research and development. In addition, they have given instructional lectures on implants and surgical techniques for other doctors and medical personnel. In return for their time and expertise, they have been paid a consulting fee.

Our office uses products from various manufacturers in the care of patients. We want to assure you that the selection of which product to use - and the care of all of our patients - is based only on what is best for the patient, not on which company makes the product.

Our orthopaedic surgeons are members of the American Academy of Orthopaedic Surgeons (AAOS), which holds its members to extremely high ethical standards to ensure that even the appearance of conflict of interest does not jeopardize the trust that patients place in our doctors.

AAOS has adopted Standards of Professionalism that require orthopaedic surgeon members to identify and disclose potential conflicts of interest to their patients, the public, and colleagues. These Standards also clearly articulate how and under what circumstances AAOS members may work with and be compensated by industry, as well as penalties for failure to comply.

You can learn more about these Standards of Professionalism at the AAOS website: http://www.aaos.org/industry relationships.

It is important to us that you are aware of these relationships with implant manufacturers. The interests of the patients come first, and we are available to answer any questions that you may have.

_____ _____

Patient Signature Date

• PLEASE COMPLETE BOTH SIDES OF THIS FORM •

Beverly Hills Orthopaedic Surgery

HEALTH HISTORY

(Confidential)

Name_____ Today's Date____/____/____

Age _____ Birth Date____/____/____ Date of last physical examination ____/____/____

What is your reason for this visit?_____

Symptoms (Check the symptoms you currently have or have had in the past year.)

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

ALL PATIENTS

Height _____

Weight_____

Blood Pressure_____

Do you smoke? ☐ Yes ☐ No

WOMEN ONLY

Are you pregnant?_____

Number of children _____

Conditions (Check the conditions you have or have had in the past.)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Diseases

Medications (List medications you are currently taking.)	Allergies (To medications or substances)
Pharmacy Name: Phone #:	

PLEASE COMPLETE REVERSE SIDE ▶

(All information is strictly confidential)

Family History (Fill in the health information about your family.)

Relation	Age	State of Health	Age at Death	Cause of Death	Check box, if your blood relatives had any of the following: Disease:	Relationship to you:
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease, Strokes	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

List all of your doctors:	Address	Phone

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give the approximate dates: _____

Serious Illness/Injury	Date	Outcome

Health Habits Check which substances you use and describe how much you use.	**Occupational Concerns** Check box if your work exposes you to the following:
☐ Caffeine	☐ Stress
☐ Tobacco	☐ Hazardous Substances
☐ Drugs	☐ Heavy Lifting
☐ Other	☐ Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions.that I may have made in the completion of this form.

Signature _____ Date___/___/___

Signature _____ Date___/___/___

Beverly Hills Orthopaedic Surgery

INJURY INFORMATION QUESTIONNAIRE

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec. # _____

Address _____

Telephone _____ Occupation _____

Please answer the following questions thoroughly and completely...

#1. What problem are we seeing you for?

_____

_____

#2. How did this happen? If unknown, put unknown.

_____

_____

#3. When did this problem start?

_____

_____

#4. Did you get hurt at work? ☐ Yes ☐ No
If yes, please give details and date of injury. Was a Worker's Comp claim filed? Please give all information.

_____

_____

_____

#5. Was this a result of an accident? ☐ Yes ☐ No
If yes, give details and date of accident. Please give all insurance information including any claim numbers.

_____

_____

_____

#6. Who referred you to us?

_____

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that-all-medical-records-and-other individually identifiable--health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPM" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 13, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Beverly Hills Orthopaedic Surgery

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

17877 W. Fourteen Mile Road • Beverly Hills, Michigan 48025-3127 • Telephone (248) 644-3920 • Fax (248) 644-2569

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☐ JPW ☐ JMW ☐ PJW ☐ TDM ☐ MDP ☐ GVS ☐ BPW

NAME _____ DATE ____/____/____

VITALS: Hgt _____ Wgt_____ Pulse_____ B/P_____ Temp_____ Age_____

☐ Right Handed ☐ Left Handed ☐ Ambidextrous

BEAUMONT ORTHOPAEDIC STAFF SERVICE ☐ YES ☐ NO

Visit due to the request of _____

CHIEF COMPLAINT _____

_____

_____

ONSET/DURATION: _____

AFFECTS: ☐ ROM ☐ SLEEPING ☐ LIFTING ☐ STRENGTH
☐ NECK PAIN ☐ NIGHT PAIN ☐ NUMBNESS/TINGLING

PROBLEM DUE TO: ☐ ACCIDENT ☐ WORK INJURY ☐ ACTIVITY ☐ SPORTS INJURY

IF YES, EXPLAIN (WHICH SPORT?) _____

_____

PRIOR TREATMENT: ☐ MRI ☐ CT ☐ PT ☐ CORTISONE ☐ X-RAYS

OTHER _____

_____

ALLERGIES: _____

MEDICATIONS: _____

_____

_____

SOCIAL / WORK HISTORY: OCCUPATION _____

SMOKING _____ / YRS ETOH _____ / YRS

PMH: SURGERIES/HOSPITALIZATIONS _____

_____

_____

_____

Dr. Initials _____