MICHIGAN ORTHOPEDIC CENTER

TODAY'S DATE_____ **SS#**_____

LAST NAME_____ **FIRST NAME**_____**MIDDLE INITIAL**_____

HOME ADDRESS_____**CITY**_____**STATE**_____ **ZIP**_____

YOUR HOME PHONE # _____ **WK PHONE** _____

SEX **MALE**_____ **FEMALE**_____ **CELL PHONE#**_____

DATE OF BIRTH _____ **EMAIL ADDRESS**_____

WHO REFERRED YOU TO OUR OFFICE? _____

FAMILY DOCTOR_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

PHONE ( )_____

CARDIOLOGIST_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

PHONE ( )_____

FIRST **INSURANCE NAME** _____
SUBSCRIBER NAME _____
DATE OF BIRTH _____
CONTRACT # _____ **COPAY AMOUNT $**____
GROUP # _____

SECOND **INSURANCE NAME** _____
SUBSCRIBER NAME _____
DATE OF BIRTH _____
CONTRACT # _____
GROUP # _____

THIRD **INSURANCE NAME** _____
SUBSCRIBER NAME _____
DATE OF BIRTH _____
CONTRACT # _____
GROUP # _____

WORK COMP ☐ ***AUTO ACCIDENT*** ☐ ***THIRD PARTY ACCIDENT*** ☐

DATE OF INJURY_____ **BODY SITE INJURED**_____
SUBMIT CLAIMS TO:_____**CITY**_____**STATE**_____
PHONE# ( )_____ **CONTACT PERSON**_____
CLAIM # _____

Michigan Orthopedic Center

J. Wesley Mesko, MD Charles J. Taunt, DO Jason M. Cochran, DO
Michael P. Swords, DO John F. Flood, DO Patrick H. Noud, MD

Name:_____Today's Date:_____Date of Birth:_____

Why are you seeing the doctor today?_____

Current problem is the result of: (Check all that apply)

☐ **Car Accident** ☐ **Work Accident** ☐ **Accident** ☐ **I do not know what brought it on**

☐ **Other_____**

***If you have too many medical problems, surgeries, medications, or allergies to fit on this form, we kindly ask you to list them on a separate sheet of paper. Thank you!*

Are you currently or have you had problems with:

Circle one:

NO	**YES**	**Fibromyalgia**	**NO**	**YES**	**Irregular Heart Beat**
NO	**YES**	**Lupus**	**NO**	**YES**	**Heart Valve Problems**
NO	**YES**	**Osteoarthritis**	**NO**	**YES**	**Cardiac Catheterization date_____**
NO	**YES**	**Rheumatoid Arthritis**	**NO**	**YES**	**Stent Placement when_____**
NO	**YES**	**Asthma/Chronic Lung Disease**	**NO**	**YES**	**Pacemaker**
		Allergist/lung doctor name_____	**NO**	**YES**	**HTN (high blood pressure)**
NO	**YES**	**Bladder/Kidney Problems**	**NO**	**YES**	**Heart Murmur**
NO	**YES**	**Prostate Disease**	**NO**	**YES**	**Reflux/GERD**
NO	**YES**	**Urinary Incontinence**	**NO**	**YES**	**HIV/TB/Polio *(if yes circle one)***
NO	**YES**	**Frequent Urinary Tract Infections**	**NO**	**YES**	**Hepatitis**
NO	**YES**	**Kidney Failure**	**NO**	**YES**	**Poliomyelitis**
NO	**YES**	**Bleeding Problems/Easy Bruising**	**NO**	**YES**	**Seizure Disorder**
NO	**YES**	**Anemia**	**NO**	**YES**	**Stomach Ulcers**
NO	**YES**	**Blood Clot or Pulmonary Emboli**	**NO**	**YES**	**Stroke**
NO	**YES**	**Diabetes mellitus**	**NO**	**YES**	**Thyroid Disease**
NO	**YES**	**Chest Pain**	**NO**	**YES**	**TIA**
NO	**YES**	**Have you seen a heart doctor**	**NO**	**YES**	**Fatigue**
		Heart Doctor name_____	**NO**	**YES**	**Dizziness**
NO	**YES**	**Congestive Heart Failure**	**NO**	**YES**	**Sickle Cell Anemia**

Are you currently or have you had problems with:

Circle one:

NO	**YES**	**Weight Gain >10lbs**	**NO**	**YES**	**Seen by a doctor who has manipulated my back**
NO	**YES**	**Weight Loss >10lbs**			
NO	**YES**	**Psoriasis**	**NO**	**YES**	**Multiple Joints Hurt**
NO	**YES**	**Sleep Apnea**	**NO**	**YES**	**Decreased Memory**
NO	**YES**	**Use CPAP at nighttime**	**NO**	**YES**	**Seizures**
NO	**YES**	**Difficulty Breathing**	**NO**	**YES**	**Hiatal Hernia**
NO	**YES**	**Constipation**	**NO**	**YES**	**Unsteadiness**
NO	**YES**	**Heart Burn**	**NO**	**YES**	**Anxiety**
NO	**YES**	**Back Pain**	**NO**	**YES**	**Depression**
NO	**YES**	**Seen by Chiropractor for Back Pain**	**NO**	**YES**	**Panic Attacks**
NO	**YES**	**Seen by Pain Clinic for Back Pain**			
NO	**YES**	**Do you have a Latex Allergy**	**NO**	**YES**	**Do you have a Metal Allergy**

Cancer: (please circle) Breast Lung Ovarian Prostate Colon Skin Uterine Other_____

Describe any medical issues not listed above:

Allergies: (foods, medications, latex, contrast dye)	Reaction?

Current Medications/Dietary Supplements: Dose (mg/ml/etc)	Frequency (times per day)

Surgeries/Hospitalizations	Year	Complications

FAMILY HISTORY

Member	Status Please Circle	Age Now or at Death	Health Condition or Cause of Death
Father	Alive Dead		
Mother	Alive Dead		
Sister/Brother	Alive Dead		
Sister/Brother	Alive Dead		
Sister/Brother	Alive Dead		
Sister/Brother	Alive Dead		

SOCIAL HISTORY

Race: ☐ Am. Indian/AK Native ☐ Asian ☐ Black or African Am. ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Other _____ ☐ Decline to Answer **Primary Language**: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Current Occupation: _____ ☐ Retired ☐ Don't work outside home ☐ Student ☐ Disabled since: _____ ☐ Last date worked: _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐ Roommate(s) ☐ Significant Other

Do you live alone? No Yes

If yes, do you have any family/friends who can assist you?_____

Children? No Yes #_____

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise?_____

History of substance abuse? No Yes **What**?_____

Smoking Status: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker

If Current or Former Smoker: ☐ Smoked Daily ☐ Smoked Some Days: ___ **packs per day** for ___ **years**.

Quit Smoking? ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years

Drink alcohol? ☐ Daily ☐ 1-2x per week ☐ 1-2x per month ☐ 1-2x per year ☐ Never

Current Height_____ Current Weight_____

MICHIGAN ORTHOPEDIC CENTER

FINANCIAL POLICY

Patient Name: _____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. We require you to read and sign an acknowledgement to this policy prior to any treatment.

PATIENT RESPONSIBILITY
Adult patients are responsible for payments as outlined in this policy at time of service. The adult accompanying a minor, the parents, and/or guardians of the minor are responsible for payments due. All patients must complete our insurance form before seeing the provider. Providing us with accurate and current insurance information is your responsibility.

- CO-PAYMENT/CO-INSURANCE PAYMENT IS DUE AT TIME OF SERVICE
- WE ACCEPT CASH, CREDIT, AND CHECKS
- WE OFFER MSUFCU'S PATIENT CREDIT CARD FOR EXTENDED PAYMENT PLANS

INSURANCE
Please be aware that some, and perhaps all, of the services provided may be non-covered services under the Medicare Part B and/or other health insurance. We will do our best to inform you of any non-covered services prior to your visit; however, you may still be responsible for payment in full for those services.

If we do not participate with your insurance company, full payment is due at the time of service. For insurance plans we participate with, we will submit your claim to your insurance company. All co-pays and deductibles are due at the time of service. In the event there are multiple insurers responsible, we will follow any legal, insurance plan outlined, or customary orders of priority in which we bill your insurance carriers.

WORKER'S COMPENSATION OR AUTO INSURANCE
In cases of liability or workers compensation, we do not consider the existence of ongoing legal action a valid reason for delaying payment of your account. The patient or their guardian is responsible for prompt payment of bills regardless of litigation that may be simultaneously occurring. When payment is received for services, we promptly fulfill our responsibility to provide your attorney with information about your treatment.

COLLECTIONS
We will provide statements of balances due for any non-covered benefits, deductibles, and/or other amounts due. We reserve the right to utilize a collections agency when any account is deemed to be in default or noncompliant with this policy. Once submitted to collections, you will need to contact our contracted collections agency for settlement and/or payment.

MISSED, CANCELLED, OR RESCHEDULED APPOINTMENTS
Please help us serve you better by keeping scheduled appointments. If you accumulate more than 3 missed appointments, it may result in a dismissal from our practice. We also require 24-hour notice for any rescheduled or cancelled appointments. Your account will be charged $50 for failure to provide 24-hour notice prior to your scheduled appointment.

By signing this document, I have read the Financial Policy, and I understand and agree to any and all terms.

_____ _____ _____

Signature of Patient or Responsible Party (i.e. Signature of Parent or Guardian) **Date** **Patient DOB**

_____ _____

Printed Name of Patient **Printed Name of Responsible Party (if applicable)**

March 2015

Michigan Orthopedic Center

J. WESLEY MESKO, MD · CHARLES J. TAUNT, JR, DO · JASON M. COCHRAN, DO · · MICHAEL P. SWORDS, DO · JOHN N. FLOOD, DO · PATRICK H. NOUD, MD
2815 SOUTH PENNSYLVANIA STE 204, LANSING, MI 48910
TELEPHONE 517-267-0200 FAX 517-267-1877
E-MAIL: info@michiganortho.com

Printed Patient Name _____

AUTHORIZATION

I, the undersigned, authorize payment of medical benefits to J. Wesley Mesko, MD/ Charles J. Taunt, Jr, DO/ Jason M. Cochran, DO/ Michael P. Swords, DO/ John N. Flood, DO/Patrick N. Noud, MD for physician services furnished to me. I understand I am financially responsible for any amount not covered by insurance. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. Patient information may also be used for research projects as allowed by patient privacy notice.

SIGNED_____DATE_____

MEDICARE
Lifetime Signature on File

I request that payment of authorized Medical benefits be made to Dr. Mesko/Dr. Taunt/Dr. Cochran/Dr. Swords/Dr. Flood/Dr. Noud for physician services furnished to me. 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 payable for related services.

SIGNED_____DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES

DATE_____

I, _____ acknowledge that I have read and/or received a copy of the **Michigan Orthopedic Center's** Notice of Privacy Practices.

_____
PATIENT/REPRESENTATIVE SIGNATURE

_____
WITNESS

Patient refused to provide a signature:_____
MOC EMPLOYEE SIGNATURE

OVER PLEASE

EMERGENCY CONTACT

Please list a name & phone number of someone NOT living with you!

NAME	RELATIONSHIP	PHONE

MEDICAL RECORDS/INFO RELEASE

I hereby authorize J. Wesley Mesko, MD/ Charles J. Taunt, Jr, DO/ Jason M. Cochran, DO/ Michael P. Swords, DO/ John N. Flood, DO/ Patrick N. Noud, MD to release my medical records/information without additional written consent to the following person(s), whom may be calling for test results, picking up x-rays, discussing general medical information, etc.

**THIS MEDICAL RECORDS/INFO AUTHORIZATION WILL BE A LIFE-TIME RELEASE UNLESS OTHERWISE SPECIFIED BY THE ABOVE NAMED PATIENT IN WRITING!

NAME	RELATIONSHIP	PHONE NUMBER

I authorize Michigan Orthopedic Center to leave a detailed message on my voicemail with any medical information including prescription refills, labs, etc. _____YES _____ NO

PATIENT SIGNATURE	*DATE*