MICHIGAN
SPORTS & SPINE CENTER

Dear Patient:

Enclosed please find the necessary forms for your upcoming appointment with Dr. Jeff S. Pierce. If you have any questions please don't hesitate to call us at 248.680.9000 (Troy office), 248.426.9944 (Livonia office) or if you would like, any questions you may have can be addressed at the time of your appointment. Filling these forms out ahead of time will help us to get to you in and out in a timelier manner.

When you come in for your appointment, please bring your driver's license, insurance card (s), worker's compensation information or any auto information you may have. Also if you have written radiologist reports, copies of any MRI's, X-Ray's or any other doctor notices addressing your injury please bring them with you.

Thank you for your cooperation,

Michigan Sports & Spine Center
248.680.9000 (Troy)
249.426.9944 (Livonia)
www.michigansportsandspine.com

MICHIGAN
SPORTS & SPINE CENTER

Date:___/___/___

MICHIGAN SPORTS & SPINE CENTER P.C.
PATIENT REGISTRATION

Patient Name: _________________________ SS#: ____-____-____ D.O.B.: __________ Age: _____ SEX: M F

Address: _____________________________ Apt#____ City: ________________________ State ___ Zip: ______

Home Phone: __________________ Mobile Phone: _______________ Occupation: _______________________

Email address #1:____________________________________ Email #2: ________________________________

Employer Name & Address: ____

____ Phone: ______________________

Emergency Contact: ____
Name Phone Relation

Name of Primary Care Physician: ___________________________________ Office Phone: _________________

Other Care Dr.: ______________________________ Phone: ________________________

Dr.:______________________________ Phone: ________________________

Which Doctor may we thank for referring you? ____

Reason for visit: ____

INSURANCE INFORMATION Type of Insurance: Personal – P Auto – A Comp - C

Primary Carrier: ____ Type: __________________________

Name of Insured: ____ Relation: _______________________________

D.O.B. ____/____/____ SS#: _____-_____-_____ Date Employed: _____/_____/_____

Employer Name & Address: ____Work Phone: ________________

Group/Claim #: ______________________________ Member ID#: _________________________________

Secondary Carrier: ____ Type: __________________________

Name of Insured: ____ Relation: ______________________________

Group/Claim#: _______________________________ Member ID#: _________________________________

I hereby authorize the release of any information concerning my (or my child's) health care, advice an treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable directly to the doctor.

____ _____/_____/_____
Signature of Patient or Parent of Minor Date

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MICHIGAN SPORTS & SPINE CENTER P.C.
PAST MEDICAL HISTORY FORM

Name: ____ Date: ____/____/____

Marital Status: Single Married Separated Divorced Widowed

Any Children: Y N How many Children ?:__________

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐
Use of Tobacco ☐ Never ☐ Previously but quit ☐ Currently Packs/Day: ________
Use of Drugs ☐ Never ☐ Type/Frequency: ________________________________
Exercise and Recreation: ____

Have you ever had any of the Following: (Please circle if YES)

Anemia	Cancer	Heart Disease	Rheumatic Fever
Arthritis	Diabetes	Hepatitis/Liver	Stroke
Asthma	Epilepsy	Hernia	Thyroid
Bleeding Tendency	GI	High/Low Blood Pressure	Ulcer
None	Other: ____________________		

Mother and Father's Medical History (Please Circle all that apply)
Arthritis Cancer Diabetes Heart Disease High/Low Blood Pressure Stroke

Have you ever had any surgeries? Y N If yes, please explain below

Procedure	Date	Dr. Name and/or Hospital
____________________	____/____/____	____________________
____________________	____/____/____	____________________
____________________	____/____/____	____________________
____________________	____/____/____	____________________

Been hospitalized (other than surgeries) Y N If yes, please explain: ____________________

Please List all medications you are currently taking: ______________________________
____
Please List all Allergies: ____

Have you ever had X-Ray, MRI, CT Scan, ETC? Y N

Name & Date of scan	Body part scanned	Name of Facility	Name of Dr. ordering scan
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

Had an Electromyography (EMG) Y N If yes, please explain: ____________________________

Have you ever had Physical Therapy? Y N If yes, last date of therapy _______ for what body part? _______
Been in a motor vehicle accident? Y N If yes, please give dates: ___________ Injuries: ___________
Had an accident at work? Y N If yes, please give dates: ___________ Injuries: ___________
Broken any bones? Y N If yes, which bones?: ______________________________

Office Review Signature: ____________________

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Review of Systems: Please indicate any personal history below.

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

☐ **Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

☐ **Ear/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Ear aches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Respiratory**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements Or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

☐ **Genitourinary**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexually difficult	No	Yes
Male – Testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female - # of pregnancies	_______	
Female - # of miscarriages	_______	
Female – date of last pap smear	_______	

☐ **Musculoskeletal**

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Integumentary (skin, breasts)**

Rash or itching	No	Yes
Change of skin color	No	Yes
Change of hair or nails	No	Yes
Varicose veins	No	Yes
Breast Pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

☐ **Neurological**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensation	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head Injury	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

☐ **Endocrine**

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes

Other drugs/medications: _______________

____

Known food allergies: ___________________

____

Environmental allergies: ________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to m health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_________________________________   _________________________

Signature of Patient, Parent or Guardian   Date

Doctor's Review

_________________________________   _________________________

Signature of Doctor   Date

MICHIGAN
SPORTS & SPINE CENTER

MICHIGAN SPORTS & SPINE CENTER P.C.
Medical Information Release Authorization

______________________________ Patient's Name

______________________________ Date of Birth

______________________________ Social Security Number

______________________________ Physician Name

I, ______________________________, authorize Michigan Sports & Spine Center, Co, to Release/obtain information contained in the medical records of the patient identified above. I understand that these records are protected under federal regulations governing confidentiality and cannot be distributed without my written consent. I understand that I may revoke this consent at any time. I expressly waive any and all privileges that might otherwise attach to such records. Federal law prohibits the recipient of the above requested information from making any further disclosure except with the specific written consent of the person to whom it pertains.

Specific information to be disclosed:

Record		Date of Service
Bone Scan	☐	______________________
MRI	☐	______________________
CT Scan	☐	______________________
X-rays	☐	______________________
Medical Records	☐	______________________
EMG	☐	______________________

______________________________ Patient Signature

______________________________ Date

______________________________ Witness

______________________________ Date

MICHIGAN SPORTS & SPINE CENTER

MICHIGAN SPORTS & SPINE CENTER P.C.
Insurance Payment Approval

______________________________ ______________________________
Patient’s Name Date

____
Employer

____
Claim Group

____
SS#/ID

I hereby instruct and direct ____Insurance Company to pay by check made out and mailed to:

Michigan Sports & Spine Center
1819 E. Big Beaver Road, Suite 210
Troy, MI 48083
TAX #38-3248485

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Michigan Sports & Spine Center
1819 E. Big Beaver Road, Suite 210
Troy, MI 48083

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charge for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf.

Date at Michigan Sports & Spine Center ____
Month Day Year

____ ____________________________
Signature of Policyholder Witness

____
Signature of Claimant, if other than Policyholder

MICHIGAN
SPORTS & SPINE CENTER

MICHIGAN SPORTS & SPINE CENTER P.C.
Notice of Privacy Practices

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and the terms of our Notice, as permitted or required by applicable law. Such revisions to our privacy practice and our Notice may be retroactive. Our revised Notice will be made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practice

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> *Treatment*. Your PHI may be used by or disclosed to any physicians or other health care providers involve with the medical services provided to you.
>
> *Payment*. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> *Health Care Operations*. Your PHI may be used or disclose as part of our internal health care operations, such health care operations may include, among other things, quality care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclosures.

Patient Access. We will provide you with access to your PHI, as describe below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X-rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other persons responsible for your care. If we determine in our responsible professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such discloser. If we determine that you are unable to provide such content, we will limit the PHI disclosed to the minimum necessary.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

MICHIGAN SPORTS & SPINE CENTER P.C.
Notice of Privacy Practices

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when require by privacy laws, worker's compensation or similar laws, public health laws court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim of suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances when required by law; we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy officer regarding our copying fees.

Discloser Accounting. You have the right to receive an account of the instances, if any in which your PHI was disclosed for purposes other than those described the following sections above; Use and Disclosures, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such request. We will be bound by such restrictions only if we agree to do so I writing signed by our Privacy Officer.

Alternate communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternate location. We will accommodate any reasonable request if it specifies in writing the alternatives means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a details explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you with a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which we will provided to you at no cost. Please contact our Privacy Office with any further questions about amending your Medical Record.

Complaints
If you believe we have violated your privacy rights, you may file a complaint with us by notifying our Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services.

Privacy Officer
Kathy Finazzo
1819 E. Big Beaver Road, Suite 210, Troy, MI 48083
Phone (248) 680-9000 Fax (248) 680-2929

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MICHIGAN
SPORTS & SPINE CENTER

MICHIGAN SPORTS & SPINE CENTER P.C.
Received Notice of Privacy Practices

THE UNDERSIGNED PATIENT OR AUTHORIZED REPRESENTATIVE OF THE PATIENT ACKNOWLEDGES THAT HE OR SHE PERSONALLY RECEIVED A COPY OF THE MICHIGAN SPORTS & SPINE CENTER, P.C'S NOTICE OF PRIVACY ON THE DATE INDICATED BELOW:

PATIENT NAME: ____

SIGNATURE: ____ DATE: ____________________

I herby give permission to Michigan Sports & Spine Center, P.C. to disclose my PHI to the personal representative(s) indicated below:

REPRESENTATIVE:___________________________TITLE/RELATIONSHIP: __________________

REPRESENTATIVE:___________________________TITLE/RELATIONSHIP: __________________

The employee made an attempt to deliver a copy of the Michigan Sports & Spine Center, P.C. Notice of Privacy Policies to the above Patient.

EMPLOYEE NAME: ______________________________________ DATE: ____________________

EMPLOYEE SIGNATURE: ________________________________ DATE: ____________________

Effective January 1, 2006, all patients will be REQUIRED TO PAY their co-pay at the time of service. Alternatively, a portion if not all of the remaining balance must be p aid prior to being seen by the doctor.

PATIENT NAME: _______________________________________ DATE: ____________________

The fee for medical record copies is $25.00. Payment due upon request.

Thank you,

Michigan Sports & Spine Center

MICHIGAN
SPORTS & SPINE CENTER

TO: ALL PATIENTS OF MICHIGAN SPORTS & SPINE CENTER P.C.

RE: NO CALL NO SHOW POLICY/FEE

Dear Michigan Sports and Spine Patient,

Effective January 1, 2005 Michigan Sports & Spine Center will charge a $25 fee for anyone that does not provide 24 hour notice to cancel their appointment and for those individuals that do not show for their appointment. This fee will be payable prior to your next scheduled appointment.

This policy is being put into effect due to the recent increase in patients not showing for their schedule disappointment. When patients do not show for their scheduled appointments, this decrease the amount of care we can provide for other patients in need. That time is set aside for you, and if you are unable to make that time, someone else could be scheduled in place.

If you have a total of three no call/no shows, your care as a patient will be suspended and you will be given a list of other physicians you may choose to visit. If you wish to come back to this office, you will not be scheduled immediately; it will take some time to schedule you in any office due to your history or poor attendance for appointments.

By signing below, I understand this policy of Michigan Sports & Spine and understand I am responsible for payment of $25.00 if I do not provide proper notice of canceling my scheduled appointment.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Witness Date

MICHIGAN SPORTS & SPINE CENTER

MICHIGAN SPORTS & SPINE CENTER P.C.
Physicians Referral Form

Patient Name: ______________________________ Phone Number: h ______________________ w __________________

Diagnosis: ________________________________ Referring Doctor: _________________________ Phone: ________________

☐ **CONSULT & TREAT**
☐ **CONSULTATION**
☐ LOW BACK PAIN
LE SYMPTOMS R L B
☐ THORACIC PAIN
☐ CERVICAL PAIN
UE SYMPTOMS R L B
EXTREMITY PAIN

☐ SHOULDER	R	L	B
☐ ELBOW	R	L	B
☐ WRIST / HAND	R	L	B
☐ HIP	R	L	B
☐ KNEE	R	L	B
☐ ANKLE / FOOT	R	L	B
☐ OTHER ______________			

☐ MANUAL MEDICINE ☐ ELECTROMYOGRAPHY

☐ UPPER EXTREMITY	R	L	B
☐ LOWER EXTREMITY	R	L	B

Rule Out ________________

☐ SPINAL INJECTIONS

☐ CAUDAL EPIDURAL
☐ COSTOVERTEBRAL BLOCK
☐ FACET INJECTION
☐ MEDIAN BRANCH BLOCK
☐ SELECTIVE NERVE ROOT BLOCK
☐ TRANSLUMBAR BLOCK
☐ OTHER ____________________________

☐ **EVALUATE & RECOMMEND**

LUMBAR LEVEL ________________
THORACIC LEVEL________________
CERVICAL LEVEL ________________

____ ________________________

Referring Physician's Signature Date

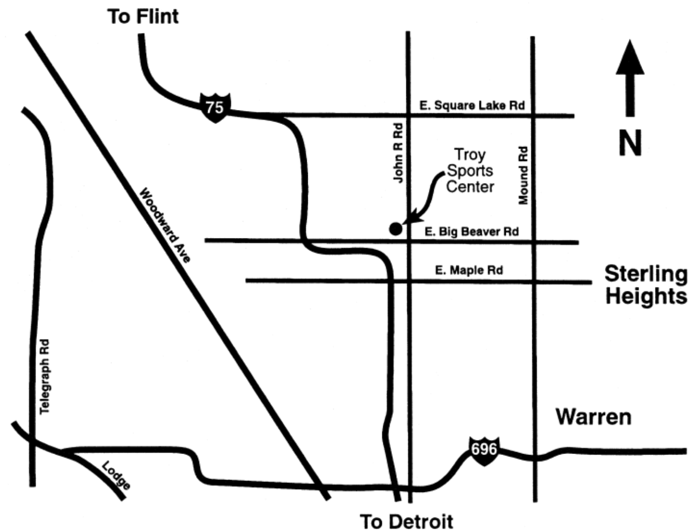
Please have Patient bring copies of all X-Ray, MRI, CT Scan or EMG Reports pertaining to this condition.

MICHIGAN
SPORTS & SPINE CENTER

MICHIGAN SPORTS & SPINE CENTER P.C.
Practice Locations

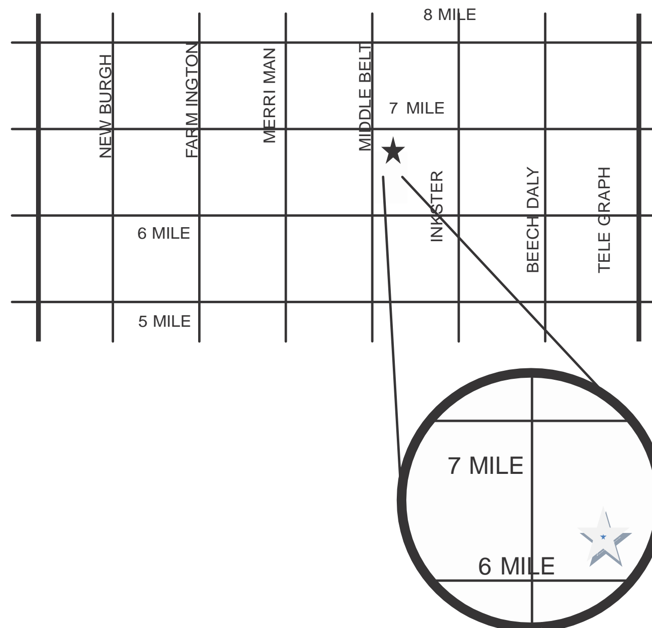
Troy

• 1819 E. BIG BEAVER RD. • SUITE 210 • TROY, MI 48083 •
248.680.9000



Livonia

• 18312 MIDDLEBELT ROAD • LIVONIA, MI 48152 •
248.426.9944



MICHIGAN
SPORTS & SPINE CENTER

Michigan Sports & Spine Center is proud to announce our monthly newsletter.

Informative topics will be:

- Injury Prevention
- Nutrition
- Sports Medicine
- Latest Treatment Options

….along with many other hot, current topics.

You will also have the opportunity to ask questions and win prizes!

All we need is your email address to get started:

Email: ____

Name: ____