ALL LINES MUST BE COMPLETED

IN THE NEW PATIENT INFORMATION PACKET.

PLEASE INCLUDE ALL MEDICATIONS
ALL NAMES OF INSURANCE COMPANIES AND ID NUMBERS
YOUR FULL NAME, ADDRESS, TELEPHONE #'S
DATE OF BIRTH & Social Security Number

IF YOU HAVE ANY QUESTIONS, PLEASE
ASK THE FRONT DESK REGISTRATION PERSON or CALL THE OFFICE (248)792-9496.

PLEASE BE SURE TO BRING ALL:
MRI DISCS AND REPORTS
X-RAYS AND REPORTS
INFORMATION PERTAINING TO YOUR INJURY

ALSO, YOU MUST BRING A CURRENT PHOTO I.D., INSURANCE INFORMATION AND INSURANCE CARDS!

THANK YOU!

WELCOME TO

Spine Specialists of Michigan, P.C.

Office Hours:
Office hours are from 9am to 5pm Monday thru Thursday; Friday 9am to 2pm. Office visits are by appointment only.

Fees and Payment:
Office visit payment and co-pays are expected at the time of service. For your convenience the office does accept cash, checks, Visa and MasterCard.

Insurance:
Please understand that your insurance policy is a contract between you and your insurance company. Claims will be submitted to your insurance carrier as long as you provide necessary information. Due to the changes in insurance policies, it is no longer possible to interpret each individual policy. It is your responsibility to know your individual coverage and to supply us with this information. If incorrect information causes a delay in billing, you may be held responsible for the cost of your care and treatment.

Forms and Prescriptions:
Our office will complete one insurance form per claim at no charge. The completion of forms is done at the discretion of the doctor and should be discussed with him at the time of your visit. There will be a fee for any additional Insurance forms.

If you are requesting any prescriptions, please do so at the time of your visit. Subsequent refills may be requested via phone. The information will then be submitted for approval and you will be notified once the medication has been called into the pharmacy. Again, the filling of prescriptions and refills are done at the discretion of the physician.

If you have any questions or concerns, please do not hesitate to call the office

(248) 792-9496

Your signature below verifies that you have read and understand the above information.

Patient's signature: _____

Guardian's signature: _____

Spine Specialists
OF MICHIGAN, P.C.

PATIENT INFORMATION **TODAY'S DATE**_____

Last Name:	First Name:	Middle Initial
Address:	City:	State & Zip
Home Phone:	Work Phone:	Cell Phone:
Birth Date:	Age:	Social Security Number:

Marital Status: (Circle One) Single Married Divorced Widowed Sex: Male Female

Email Address:

Emergency Contact Person:_____ **Phone:** _____

Relationship: _____

Are you currently working? (Circle One) Yes No

If no, what is your last day of work: _____

EMPLOYMENT INFORMATION

Employer Name:	Phone:	Your Occupation:
Address	City	State & Zip

REFERRING DOCTOR OR INDIVIDUAL:

Name:		Phone:
Address	City	State & Zip:

Chief Complaint :

PRIMARY CARE PHYSICIAN:

Name:		Phone:
Address	City	State & Zip:

Is your Chief Complaint the result of an Auto Accident?
Yes ☐ **No** ☐ **State Auto Accident Occurred In:** _____

Was a police report filed? **Yes** ☐ **No** ☐ **If so, please provide a copy.**

Spine Specialists OF MICHIGAN, P.C.

Is your Chief Complaint the result of a Working Injury? Yes ☐ No ☐ Is your Chief Complaint the result of a Slip and Fall? Yes ☐ No ☐	
PLEASE EXPLAIN IN DETAIL HOW YOUR INJURY/ACCIDENT HAPPENED: _____ _____ _____	
What is the Date of your Injury?	
What is your attorney's name? _____ Phone Number: _____ N/A ☐	
CASE MANAGER INFORMATION:	
Name:	Phone:
ADJUSTOR INFORMATION:	
Name:	Phone:
Claim Number:	Policy Holder's Name:
PRIMARY INSURANCE INFORMATION:	
Insurance Company's Name:	
Subscriber's Name:	Subscriber's Date of Birth:
Subscriber's Contract/Claim Number:	Subscriber's Group Number:
Subscriber's Relationship to patient (Circle One) Self Spouse Dependent	
Subscriber's Employer, or Retired From:	
Employer's Address:	Phone:
SECONDARY INSURANCE INFORMATION:	
Insurance Company's Name	
Subscriber's Name	Subscriber's Date of Birth:
Subscriber's Contract/Claim Number	Subscriber's Group Number
Subscriber's Relationship to patient (Circle One) Self Spouse Dependent	
OTHER INSURANCE INFORMATION:	**Phone:**

Patient Name: _____ *Date:* _____

PATIENT INFORMATION

Auto accident insurance company name: _____ Policy # _____

Address of claim office: _____

Name of claim adjuster: _____ Phone: _____

Claim number: _____ Policy holder's name: _____

State accident occurred in _____ City_____

Worker's compensation insurance company name: _____

Address of claim office: _____

Name of claim adjuster: _____ Phone:_____

Claim number: _____ Policy #: _____

Please provide a letter of authorization from your employer or worker's compensation insurance company. If you do not have one, you are responsible to have a letter faxed to (248)792-9628. Without written authorization for treatment, you will not be able to be examined.

Authorization for Insurance & Medical Information: Authorization to release information: I hereby authorize Spine Specialists of Michigan, P.C. to receive or release any medical or other information that may be necessary for my medical care or in processing insurance applications. This includes the sharing of information with all parties involved in my care. All means of data exchange may be utilized, including electronic transmission.

Assignment of insurance benefits: I hereby authorize direct payment of medical benefits to Spine Specialists of Michigan, P.C. for services rendered by one of their physicians or for services rendered under the supervision of the physician. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization for Medicare and Medicaid:
I certify that the information given by me in applying for payment is correct. I authorize release of all records on their request. I request that payment of authorized benefits be made on my behalf.

Patient Name (print): _____

Patient's Signature: _____

Guardian's Name & Signature (if applicable): _____

NOTICE OF PRIVACY PRACTICES
Effective date: April 14, 2003

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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE SPINE SPECIALISTS OF MICHIGAN, P.C.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees.

This notice will tell you about the ways in which we may use and disclose your medical information. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

1) Make sure that medical information that identifies you is kept private
2) Give you this notice of our legal duties and privacy practices with respect to Medical information about you; and
3) Follow the terms of the notice that is currently in effect.

How this Office May Use and Disclose Your Medical Information
The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories :

For Treatment. We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patient.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at this office.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Worker's Compensation statutes and various public health statutes in connection with required reporting of certain disease, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities. We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement. We may release medical information about you if required by law when asked to do so by a law enforcement official.

Coroners and Medical Examiners. We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Your Rights Regarding Your Medical Information :
You have the following rights regarding the medical information this office maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To inspect and copy your medical information, you must submit your request in writing to the Spine Specialists of Michigan, P.C. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review contact the Privacy Officer at the Spine Specialists of Michigan, P.C.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by this office.

To request an amendment, your request must be made in writing and submitted to the Spine Specialists of Michigan. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) Was not created by us;
b) Is not part of the medical information kept by this office;
c) Is not part of the information which you would be permitted to inspect and copy; or
d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of you medical information.

We are not required to agree to your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Spine Specialists of Michigan.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Spine Specialists of Michigan, P.C. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, contact the Spine Specialists of Michigan, P.C.

Revisions to This Notice.

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised notice in this office. Any revised notice will contain on the first page, the effective date. In addition, each time you visit the office we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact Penny Wilcox at 248-792-9496.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Other Uses of Medical Information
Other Uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

Signature: _____ **Date:** _____

SPINE SPECIALISTS OF MICHIGAN, P.C.

LEIN LETTER

Patient's Name: _____ **Date of Birth:** ____/____/_____

Patient #: _____

I _____**acknowledge a lien on any monies I receive in a settlement of my claim for injuries arising out of the medical expenses rendered to me by Dr. Louis N. Radden, D.O.**

Date of Injury

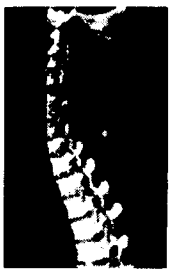
____/____/_____

Date of Episode

____/____/_____

Patient's Signature _____**Date:** ____/_____/_____

Lienletter.842011



Spine Specialists of Michigan, P.C.

Louis N. Radden, D.O.
Reconstructive Spine Surgery
Board Certified

ASSIGNMENT OF BENEFITS/PATIENT RELEASE FORM

I request that payment of authorized insurance benefits and/or Medicare benefits, on my behalf, be paid to _____ for any equipment or services provided to me by Spine Specialists of Michigan, P.C. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services.

I understand that I am financially responsible for any charges not covered by my health care benefits. I understand that it is my responsibility to notify Spine Specialists of Michigan, P.C. of any changes in my health care coverage. If a change in my health care coverage is not reported prior to the services being provided, I understand that I am financially responsible for any charges if payment is denied.

Patient Signature: _____

Date: _____

(248)792-9496 -- Fax (248)792-9628
32270 Telegraph Rd., Ste. 110 – Bingham Farms, MI 48025

Louis N. Radden, D.O.
Reconstructive Spine Surgery
Board Certified

ASSIGNMENT OF RIGHTS

I, _____, do hereby assign my rights to collect No-Fault Insurance Benefits in the form of medical expenses from my auto insurer _____ to Dr. Louis Radden, D.O. of the Spine Specialists of Michigan, P.C., relating to my past treatment with Dr. Louis Radden, D.O. of Spine Specialists of Michigan, P.C. This assignment of my rights does not include my right to any other No-Fault benefits that I may be entitled to under the Michigan No-Fault Act.

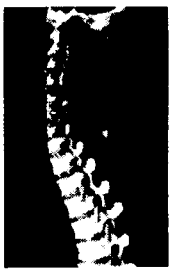
It is further expressly understood that should I pursue litigation (a lawsuit) against my auto insurer _____, that I or my counsel have authority to collect any bills owed to Spine Specialists of Michigan, P.C. on their behalf. I agree to immediately notify Spine Specialists of Michigan, P.C. to pursue their rights of medical expenses owed for my care, recovery and rehabilitation.

It is further expressly understood that this assignment of rights in no ways relieves me of my obligation for the payment of any medical bills that I have incurred at Spine Specialists of Michigan, P. C. I understand that this assignment of rights simply allows Dr. Louis Radden and/or Spine Specialists of Michigan, P.C. to collect directly from my auto insurer. Should any judge or jury determine that my injuries are not related to a motor vehicle accident, I understand that this assignment of rights shall have no effect, and I will be obligated to pay the amount owed to Spine Specialists of Michigan, P.C.

Patient Signature & Date: _____

Witness: _____

(248) 792-9496 – Fax (248) 792-9628
32270 Telegraph Rd., Ste. 110 – Bingham Farms, MI 48025



Spine Specialists of Michigan, P.C.

LETTER OF GUARANTEE

PATIENT: (Print Name) _____

D.O.B.: _____

I acknowledge the lien of monies in reference to the claim of injuries arising from the

_____

Date of Injury/Accident/Episode

I also guarantee payment of medical expenses to Louis N. Radden, D.O., Spine Specialists of Michigan, P.C. out of the settlement of my claim related to the above date of injury and or accident/episode.

_____ _____

SIGNATURE DATE

(248)792-9496 -- Fax (248)792-9628
32270 Telegraph Rd., Ste. 110 – Bingham Farms, MI 48025