

Center for Orthopedic Surgery P.L.C.

21550 Harrington Suite A
Clinton Twp, MI 48036
Phone: (586) 627-1100
Fax: (586) 627-1120

8180 26 Mile Road Suite 102
Shelby Twp, MI 48316
Phone: (586) 627-1100
Fax: (586) 627-1140

Kevin Hanlon, D.O.
James Kehoe, D.O.

Patient Information Sheet

Patient Last Name: _____ First Name: _____ Middle Init. _____
Street Address: _____ City: _____ State: _____ Zip: _____
Telephone Number: (____) _____ Social Security Number: _____ Height: _____ Weight: _____
Work Number: (____) _____ Cell Number: (____) _____ Birth date: _____ Age: _____ Sex: _____
Marital Status: _____ Employer: _____ Job Description _____
Your Family Physician: _____ Phone Number (____) _____

Insurance Information

Subscriber's Last Name: _____ First Name: _____ Birth date: _____
Social Security Number: _____ Employer's Name: _____ Telephone Number: (____) _____
Employer's Address: _____

I hereby authorize payment directly to Drs. Hanlon//Kehoe of the surgical and/or medical benefits payable to me for the services as described but not to exceed the reasonable and customary charges for those services.
I authorize any holder of medical or other information about me to release such information about me to release such information as necessary to process these claims or related medical claims.
I permit a copy of this authorization to be used in place of the original.
I understand I am financially responsible to the doctor for the charges not covered by this agreement and any late fees applied to the account.

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

Patient History

How did you hear about our practice?: _____
Current problem for this evaluation:
Body Part: _____ Right _____ Left _____ Both _____ Are you: Right/Left Handed
When did your problem begin? _____ If an injury or accident, Date: _____ Auto/Slip & Fall/ Other
Has an attorney been consulted: _____ Is your problem a result of an accident? Yes No
Explain: How? When? Where? _____

Have you had any Treatment/X-Rays? Yes No If so, by whom? _____
When? _____ Where? _____

Do you have any Drug Allergies? Yes No Please List: _____

List any medications you are currently prescribed and reason for taking. Please include over the counter
Medications: _____

General Past Medical History

Have you had any serious illnesses? Yes No

Please List: _____

Review of systems / medical history:

Other Orthopedic Problems: **None** Arthritis ___ Joint swelling ___ Tendonitis ___ Sprain of _____
Other _____

Circulatory Problems: **None** Blood Clots ___ Phlebitis ___ Stroke ___ Swelling ___
Other _____

Heart Disease: **None** Heart Attack ___ Heart Failure ___ High Blood Pressure ___
Other _____

Respiratory Problems: **None** Asthma ___ Wheezing ___ Short of Breath ___ Emphysema ___
Other _____

Gastrointestinal Problems: **None** Ulcer ___ Diarrhea ___ Nausea & Vomiting ___ Weight Change ___ Hepatitis ___
Bloody Stool ___ Other _____

Genitourinary: **None** Infection ___ Pain of urination ___ Frequency of urination ___
Other: _____

Neurological: **None** Headaches ___ Fainting ___ Seizures ___ Stroke ___ Paralysis ___ Numbness ___
Head injury ___ Other _____

Emotional Problems: **None** Nervous Breakdown ___ Depression ___ Stress ___ Sleeplessness ___
Drug/Alcohol ___ Other _____

Bleeding Problems: **None** Other _____

Endocrine / Metabolic: **None** Diabetes ___ Thyroid ___ Hypoglycemia ___ Other _____

Genetic / Inherited Disorders: **None** List _____

Gynecological: (females) Last Menstrual Period: _____ Last Pap _____ Pregnancies: _____

Complications: _____ Children: _____

Past Surgeries:

Please List: _____

Life Style

Caffeine: Coffee / Tea Amount per day _____ per week _____
Tobacco: Cigar / Cigarettes / Smokeless Tobacco Amount per day _____ per week _____
Alcohol/ **Beer**: Amount per day _____ per week _____ **Wine**: Amount per day _____ per week _____
Other substances: list _____

Do you consider your overall health as:

Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___ Other _____

Certificate of Authenticity

I hereby certify that the above information is true and correct to the best of my ability.

Signed: _____ Date: _____

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Dr. Kevin Hanlon D.O.
Dr. James Kehoe D.O.

I, _____, give Center for Orthopedic Surgery permission to :

___ To call my home about appointments

___ To leave messages on my answering machine at _____

___ To call my work place if necessary at _____

___ To leave messages at my email address at _____

___ May leave messages concerning appointments with _____

Relationship _____

___ May discuss my medical condition with _____

___ Release a copy of my medical records to _____

Patient or Legal Guardian's Signature: _____ Date _____

Witness: _____ Date: _____

• **Authorizations expire 1 year from date of signature, unless stated otherwise**

Our office will NOT fax any confidential information unless deemed necessary and under the direction of the Privacy Officer for Center for Orthopedic Surgery.

Turn page over more information on the back→

Center For Orthopedic Surgery P.L.C.

Dr. Kevin Hanlon D.O.
Dr. Ronald Meisel D.O.
Dr. James Kehoe D.O.

Notice and Acknowledgement

Acknowledgement Waiver

I acknowledge that I have waived my right to receive a copy of the Notice of Privacy Practices at this time and may receive a copy at a later date. I am aware that Center for Orthopedic Surgery requires my signature to release my protected health information on a separate form and will NOT release my confidential information unless under my authorization.

Patient Or Legal Representative

Date

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

Patient or Legal Representative

Date

21550 Harrington Ste A ~ Clinton Twp, MI 48036
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Payment Policy Authorization

I understand that all charges incurred are my personal responsibility .I Authorize payment for services rendered to be paid directly to my Physician(s), and if correct information is supplied at the time of visit, that managed care insurance is filed with the contracted carriers. The Patient is responsible for all residual balances, including but not limited to co-pays, deductibles, coinsurance, master medical and charges not paid or covered by insurance for any reason, after consideration of contractual adjustments. There will be a \$15 late fee and \$5.00 statement fee applied monthly to any and all unpaid balances, these fees will be applied to my account immediately for not paying the above mentioned balances at the time they are in the office. _____

If your insurance company does not pay in full within 90 days the balance is due becomes your responsibility to obtain payment from your insurance company. We will assist you in any way but the balance WILL be transferred to you and remain on your side until the claim is paid._____

Surgical patients are required to pay their deductible and coinsurance amounts PRIOR to their scheduled surgery date unless otherwise stipulated by contract with a managed care insurer. _____

In addition to the principle amount owed, I agree to pay 35% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and cover costs arising out of any litigation concerning the collection of this account. _____

I acknowledge that I have fully read and understand all of the terms and conditions, as well as any payment terms associated with this contract and herby agree to be bound by all of the above terms.

If I have a **Master Medical** policy I understand that my office visit must be paid at the time of service, and give Center For Orthopedic Surgery my permission to submit the billing for my reimbursement.

If I am also a **Medicare patient**, I request payment of authorized Medicare benefits be made on my behalf to Center for Orthopedic Surgery for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents needed to determine these benefits payable for related services.

Patient Signature*

Date

**Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is unable to sign or is a minor.