John E. Samani, M.D.
BOARD CERTIFIED
FELLOWSHIP TRAINED

Phone: (248) 373-7600
Fax: (248) 373-7443
www.instituteforathleticmedicine.com

937 North Opdyke Road
Auburn Hills, MI 48326

Appointment Date: _____ _____ at _____
With: John E. Samani, M.D.

Dear Patient:

Welcome to our practice and thank you for choosing us for your orthopedic care. For your convenience and to expedite your registration, please complete the attached patient information forms. Upon arriving at the office, please present the completed forms with your insurance card(s) to the receptionist.

Please Note

Copays deductibles and coinsurances for office visits and procedures are due at the time of your appointment. You will be required to provide a credit or debit card, we are no longer accepting checks or cash.

If your insurance requires a referral form for this visit, it is your responsibility to obtain it from your primary care physician.

If your visit is related to an automobile accident, worker's compensation or slip and fall injury, written authorization must be received prior to services being rendered. Please bring the necessary information with you or have your insurance adjuster/representative forward the following information:

Complete claims address & telephone number
Case file number
Type & date of injury
Adjuster's name & telephone number

New patients should bring current MRI or X-Ray films and reports, if available. If being treated for a knee condition, please wear/bring a pair of shorts with you; if you are being treated for a shoulder condition, please wear/bring a sleeveless top.

We look forward to providing your medical care and if we can be of further assistance, please do not hesitate to contact our medical staff.

We do ask that if you are unable to keep your appointment to please notify the office at least 24 hours in advance. In case of no shows or cancellations with less than 24 hours notice, a charge of $35.00 will be assessed. In the case of cancellation without acceptable notice, you will be asked to seek care elsewhere. We appreciate your consideration in this matter.

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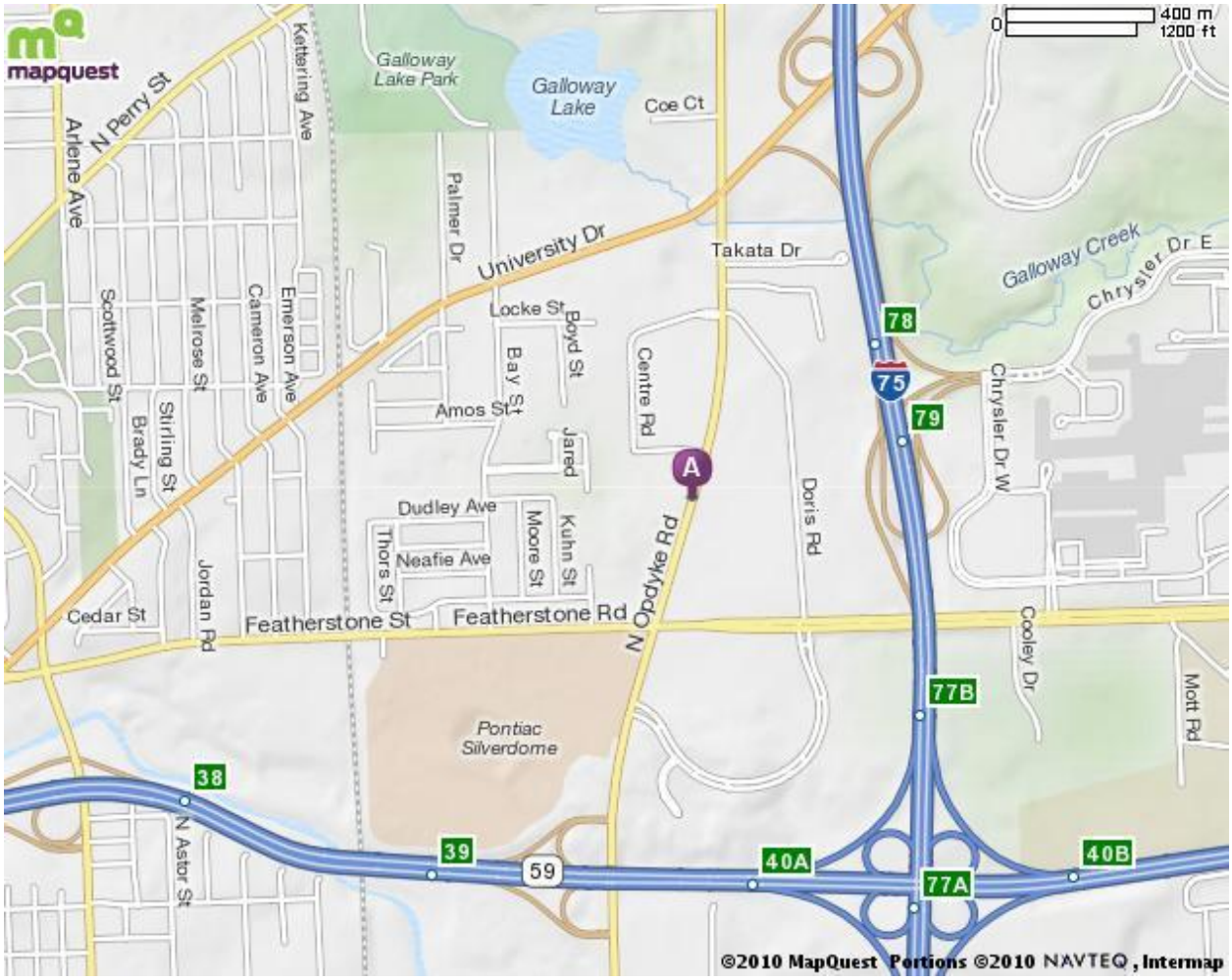
AUBURN HILLS



The Institute for Athletic Medicine is located at 937 North Opdyke Road in Auburn Hills, between University Drive and Featherstone. Our building is on the west side of Opdyke, north of Lellie's Restaurant and across from Burger King. To enter the patient entrance and parking lot located on the north side of the building, you will need to make a right at our mailbox and follow the driveway.

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Patient Information

Name_____ Birthdate _____/_____/_____ Age _____ ☐M ☐F
Last *First* *MI*

Address _____
Street *Apt #* *City* *State* *Zip Code*

Social Security # _____ Marital Status S M W D Referring Physician _____

Home Phone _____ Cell Phone _____ Work Phone _____ Email: _____

Emergency contact: _____ Relationship:_____ Phone:_____

Names of those to whom medical information may be disclosed:

(1) _____ Relationship to Patient:_____

(2) _____ Relationship to Patient:_____

*****IS THIS IS A WORK OR AUTO-RELATED INJURY? ☐YES ☐NO IF YES, COMPLETE THE WORK/AUTO RELATED INJURY FORM**

Primary Insurance Company _____ Employer Name _____

Subscriber Name_____ Birthdate _____/_____/____ Age _____ ☐M ☐F
Last *First* *MI*

Subscriber Social Security # _____ Relationship to Patient _____

Contract # _____ Group # _____

Secondary Insurance Company _____ Employer Name _____

Subscriber Name_____ Birthdate _____/_____/____ Age _____ ☐M ☐F
Last *First* *MI*

Subscriber Social Security # _____ Relationship to Patient _____

Contract # _____ Group # _____

GUARANTOR INSURANCE INFORMATION ***Person Responsible for Payment of Account***

Name _____ Birthdate _____/_____/_____ Age _____ ☐M ☐F
Last *First* *MI*

Address _____
Street *Apt #* *City* *State* *Zip Code*

Subscriber Social Security # _____ Relationship to Patient _____

Primary Phone _____ Alternate Phone _____

I authorize the release of medical records in order to process any medical claims. I understand that I am responsible for any professional services not paid for by my insurance carrier. I certify that the above information is accurate to the best of my knowledge.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

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WORK OR AUTO RELATED INJURY FORM

ALL WORK OR AUTO RELATED INJURIES **MUST**
HAVE A CLAIM FILED PRIOR TO YOUR OFFICE VISIT WITH THE DOCTOR.

This means you **MUST FIRST** file a claim with your employer or auto carrier.

BRING WITH YOU TO YOUR INITIAL OFFICE VISIT THE FOLLOWING WITH ALL REQUESTED INFORMATION.
This information will allow us to more promptly and accurately process any appropriate correspondence.

Patient Name_____ Birthdate ____/____/____ Age _____ ☐M ☐F
Last ***First*** ***MI***

Nature of Injury _____

Date of Injury _____

This injury is a result of: ☐ Accident at work ☐ Auto accident State of Accident _____

Send Claims to:

Company _____

Address _____

Phone _____ Fax _____

Claim #. _____ Contact Person_____

Employer Information:

Company _____

Contact _____

Address _____

Phone: _____ Fax _____

Signature of Patient _____ Date _____

THERE IS AN *INITIAL $20.00* PROCESSING FEE FOR EACH DISABILITY, LEAVE OF ABSENCE, OR WORK RELATED FORM TO BE COMPLETED BY OUR OFFICE. PLEASE PROVIDE THIS FEE WITH YOUR FORM AND A POSTAGE PAID ENVELOPE. ANY ADDITIONAL FORMS WILL REQUIRE A *$10.00 PROCESSING FEE*.

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Patient Medical History

Patient Name_____ Birthdate ____/____/____ Age _____ ☐M ☐F
Last ***First*** ***MI***

Height _____ Weight _____

Ethnicity & Race is a federal requirement mandated by CMS-Centers for Medicare & Medicaid Services

Ethnicity ☐African ☐Cuban ☐Hispanic or Latino ☐Irish ☐Italian ☐Jewish ☐Native American ☐Not Hispanic or Latino ☐Polish

Race ☐White ☐Black ☐American Indian ☐Asian Indian ☐Chinese ☐Filipino ☐Hispanic ☐Japanese ☐Vietnamese ☐Hawaiian ☐Guamanian ☐Samoan

Preferred Language ☐English ☐Spanish ☐Other

Chief Complaint

Extremity ☐Left ☐Right **Body Part** ☐Knee ☐Shoulder ☐Other _____

Why are you seeing the doctor today? _____

Current problem is a result of: (check all that apply)
☐ Lifting ☐ Pulling ☐ Pushing ☐ Twisting ☐ Falling ☐ Bending

☐ Reaching ☐ Squatting ☐ Hit by object ☐ Unknown

Pain level rated at ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you been treated by an orthopedic surgeon in the past year? Yes ☐ No ☐
If yes, please complete:

Physician's name _____ Phone Number_____

Address _____
Street *Suite #* *City* *State* *Zip Code*

What were you treated for?_____

Have you had previous x-rays? Yes ☐ No ☐ Date Taken _____/_____/_____

Location _____ Results _____

Have you been to the emergency room/urgent care recently for your problem? Yes ☐ No ☐ Date ____/_____/_____

Name of Facility _____

Referred to for follow-up _____

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Please list <u>all</u> the medications you are currently taking:

Medications Name	**Dose**	**How Long**	**Side Effects**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

Adverse Reaction: _____ _____

Pharmacy
Pharmacy name _____

Address _____ City _____ State _____ Zip _____

Phone Number _____Fax:_____

Patient Medical History

Hospitalizations	**Year**	**Reason**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Surgical History

Surgeries	**Year**	**Reason**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had general anesthesia? ☐Yes ☐ No

Have you had any problems with anesthesia? ☐Yes ☐ No Describe _____

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SOCIAL HISTORY

☐ Work in Home ☐ Occupation _____ ☐ Retired ☐ Unemployed ☐ Disabled

☐ Student School _____ Primary Sport _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ Yes ☐ No Do you live alone? ☐ Yes ☐ No

Exercise? ☐ Daily ☐ 3x Week ☐ 1x Week ☐ 1x Month ☐ Never

What type of exercise or Primary sport? _____

Are you on a special diet? ☐ Yes ☐ No Describe _____

PATIENT'S PHYSICIAN INFORMATION

Family Physician? Yes ☐ No ☐
If yes, please complete:

Physician's name _____

Address _____ City _____ State _____ Zip _____

Office Phone Number _____ Fax:_____

Cardiologist? Yes ☐ No ☐
If yes, please complete:

Physician's name _____

Address _____ City _____ State _____ Zip _____

Office Phone Number _____ Fax:_____

Oncologist? Yes ☐ No ☐
If yes, please complete:

Physician's name _____

Address _____ City _____ State _____ Zip _____

Office Phone Number _____ Fax:_____

Pain Management? Yes ☐ No ☐
If yes, please complete:

Physician's name _____

Address _____ City _____ State _____ Zip _____

Office Phone Number _____ Fax:_____

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CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Notice of Privacy Practices Acknowledgement

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please carefully review the HIPAA Notice of Privacy Practices Form that this office has prepared. Please also see our notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "payment" and "health care operations".

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (Print) **Date**

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

_____

Signature

STATEMENT OF FINANCIAL POLICY

THE INSTITUTE OF ATHLETIC MEDICINE
AUBURN HILLS

Thank you for choosing us as your health care provider! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our statement of financial policy, which we require all of our patients to read, understand and sign prior to any non-emergent treatment or care.

In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card. Please cooperate with our reception staff in providing accurate information.

About your insurance coverage

- **Co-pay-** Co-pays are a set dollar amount that you are required to pay according to your insurance policy at each office visit. Every patient will be responsible for paying their office visit **copay at the check-in desk** on the date of service.
- **Deductibles**-This is a set dollar amount that is required annually to be paid by the insured. The insurance will not pay any of your claims until this amount is paid by the patient. We are required to collect this amount in full; we are not allowed to adjust off any portion of this payment.
- **Commercial/Indemnity Insurance-** Your policy is a contract between you and your insurance company. Since we are not a party to that contract, your account balance, and whether your insurance pays or not is your responsibility. As a courtesy, we will file a claim on your behalf.
- **Medicare-** as required with our participation we will file claims with Medicare. You are responsible to pay for services not covered under the Medicare program and all Medicare co-payments. If Medicare does not forward claim information to your secondary insurance carrier, our office will do so and attach the primary explanation of benefits. **If you have a Medicare HMO or Medicare Advantage plan, please contact our office to see if we participate. We do not participate with all Medicare Replacement plans.***
- **Managed Care Plan (PPO, POS, HMO) -** You are responsible for paying any co-payments, deductibles and non-covered services. **It is your responsibility** to verify a physician's participation in your health plan prior to making an appointment. Please understand that if you fail to do so your insurance carrier may not authorize the visit. We must comply with your insurance company's rules and most insurance companies will NOT issue a retroactive referral for services.
- **Self-Pay or Self-Filing-** Patients who do not have insurance coverage, who are unable to provide us with valid insurance information, or who wish to file their own insurance claims are responsible to pay **100%** of the charges at the time services are rendered.
- **Work-Related or Auto Related Injury-** We require written approval or authorization for work-related and auto-related claims. If a written denial of the claim is received you will be responsible for payment in full.
- **Returned Checks-** The fee for each returned check for insufficient funds is $25.00. The fee will be automatically charged to your patient account when your check is returned from the bank.
- **Surgical Procedures-** Pre-authorization will be obtained by our office if needed. If your deductible has not been satisfied for the year you will be required to pay a deposit for the surgery. The deposit amount will be based on the amount of your deductible and the type of procedure that you are scheduled for. This deposit will need to be paid approximately one week prior to surgery.

*****Your insurance policy determines the amount you are responsible to pay. *****
****Medical Providers are not allowed to adjust off any Co-payments or Deductibles*****

Our staff has been trained to understand many insurance policies, but they DO NOT have all the answers about your specific benefits. Please contact your insurance company to obtain detailed information about your plan coverage.

Any outstanding balances from previous visits will be collected prior to being seen by the doctor, **regardless of receiving a statement.** If balances cannot be paid in full, your appointment will be rescheduled until the balance is taken care of.

******Our office does not offer Payment Plans.*******

I HAVE READ THE STATEMENT OF FINANCIAL POLICY
I UNDERSTAND AND AGREE TO THE POLICY

_____	_____	_____
Patients Name (Please Print)	**Signature of Patient or Guarantor**	**Date**