

REQUEST FOR RELEASE OF MEDICAL RECORDS OR X-RAYS



BAY STREET
ORTHOPAEDICS & SPINE

To _____

PRINT PHYSICIAN'S NAME

Address _____

City _____ State _____ Zip _____

I hereby request the release of my medical records including office notes, testing results regarding:

NOTE APPROXIMATE DATES OF SERVICE

X-ray, MRI, CT Films (actual films or CD)

INDICATE BODY PART

Please release records to me at:

Address _____

City _____ State _____ Zip _____

Please release records to provider noted above.

Please release records to person (other than myself) noted below:

Name _____

Fax Number _____ Phone Number _____

Address _____

City _____ State _____ Zip _____

Patient Name (print) _____

Phone Number _____ Date of Birth _____

Patient Signature _____ Date _____

PARENT SIGNATURE FOR MINOR

Date Released _____

Patient # _____

Bay Street Provider _____

BAYSTREETORTHO.com

800.968.5155 · 231.347.5155 · F 231.347.6128

PETOSKEY · CHARLEVOIX · CHEBOYGAN · ST. IGNACE · GAYLORD · ROGERS CITY · TRAVERSE CITY

PAYMENT POLICY

Welcome! Please review our payment policy and sign where indicated.
If you have any questions please do not hesitate to contact our billing department.
You can reach them at 231.347.5155, Monday – Friday, 9am – 4:30pm.



BAY STREET
ORTHOPAEDICS & SPINE

Insurance Acceptance Guidelines

The following is a list of insurance companies we are in Network (participate) with:
Medicare & Medicare HMO's, Medicaid & Medicaid HMO's, Priority Health, BCBS, Blue Care Network, McLaren Health Plan, Auto, Work Comp, ASC, NGS, Aetna, Cigna, Tricare, Triwest (Optum), Champ VA, and Tribal Insurance.

All other insurances are considered out of network and you, as the patient, are responsible for any balance left unpaid. We do not participate with insurance companies from outside the United States. Please see our 'Self Pay Payment Policy' below for details.

Co-Pays/Deductibles

All co-pays and deductibles are due at the time of your visit.

Self Pay (no insurance) Payment Policy

It is our policy to collect a \$250 deposit at your first appointment. Please understand this is strictly a deposit and may not cover the entire cost of treatment. You should receive a bill within 30 days for the remainder of your balance. If you do not receive a bill or have questions regarding your statement, please contact us directly at our main office at 231.347.5155.

If you choose to pay your balance in its entirety on the same day services are rendered you will receive a 10% discount. If surgery is necessary, an additional deposit may be required seven days prior to surgery.

Work Comp and/or Auto Claims

Valid work comp and auto information is required prior to your appointment. Failure to provide complete billing information, including a claim number, will result in a transfer of responsibility to the patient. Please see 'Self Pay (no insurance) Payment Policy' above for further details.

Unpaid Balances

Any unresolved and/or unpaid balances on your account beyond 90 days of the visit or failure to contact our billing department with changes in your address and/or financial situation will place your account into a delinquent status. If this results in the account being sent to a collection agency, a \$25 non-refundable fee will be added to the outstanding balance. Delinquent balances are required to be paid in full prior to scheduling future appointments for NEW orthopaedic issues, unless payment arrangements are made.

No Show Appointments

As a courtesy to our office, as well as to those patients who are waiting to schedule with their physician a minimum of 24 hours' notice is required. Failure to cancel or reschedule your appointment with at least 24 hours' notice may result in a \$25 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

Thank You

We at Bay Street Orthopaedics & Spine appreciate your patronage and value you as a patient. Thank you for reviewing this payment policy. By signing below you state that you have read, understand, and agree to its contents.

Signature

Date

Print Name

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS



BAY STREET
ORTHOPAEDICS & SPINE

I consent to the use or disclosure of my protected health information by Bay Street Orthopaedics & Spine, including the physician practices which participate under the name, for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Bay Street Orthopaedics & Spine. I understand that diagnosis or treatment of me by the physicians of Bay Street Orthopaedics & Spine may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bay Street Orthopaedics & Spine is not required to agree to the restrictions that I may request. However, if Bay Street Orthopaedics & Spine agrees to the restriction that I request, the restriction is binding on Bay Street Orthopaedics & Spine and the individual physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that Bay Street Orthopaedics & Spine or its physicians have taken action to reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Bay Street Orthopaedics & Spine Notice of Privacy Practices prior to signing this document. The Bay Street Orthopaedics & Spine Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in performances of healthcare operations of the Bay Street Orthopaedics & Spine. The Notice of Privacy Practices for Bay Street Orthopaedics & Spine is also provided at the front desk and on the Bay Street Orthopaedics & Spine website at BAYSTREETORTHO.com. This Notice of Privacy Practices also describes my rights and the Bay Street Orthopaedics & Spine duties with respect to my protected health information.

Bay Street Orthopaedics & Spine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Bay Street Orthopaedics & Spine website, calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

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PATIENT HISTORY

Patient Name _____

Date of Birth _____



BAY STREET
ORTHOPAEDICS & SPINE

MEDICAL ALLERGIES with REACTIONS

SURGICAL HISTORY

PAST MEDICAL HISTORY

- | | | | | | |
|--|--------------------------------------|---|--|---------------------------------|--------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other |

HOBBIES

SMOKING STATUS

- Never Former/Date Quit Current/Packs per day

FAMILY MEDICAL HISTORY

- | | | | | |
|---------------|---------------------------------|---------------------------------|----------------------------------|---------------------------------|
| HEART DISEASE | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| DIABETES | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| CANCER | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| ARTHRITIS | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |
| OTHER | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister |

PAIN SPECIALIST

- Do you receive pain medication from another provider? Yes No
- Are you on a pain contract? Yes No If YES, by what doctor _____

SOCIAL HISTORY

- Alcohol Yes No Frequency _____

Marital Status _____

Occupation _____

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MEDICATIONS		
Name	Dosage	Reason for Taking

Signature

Date

Print Name

SPINE QUESTIONNAIRE



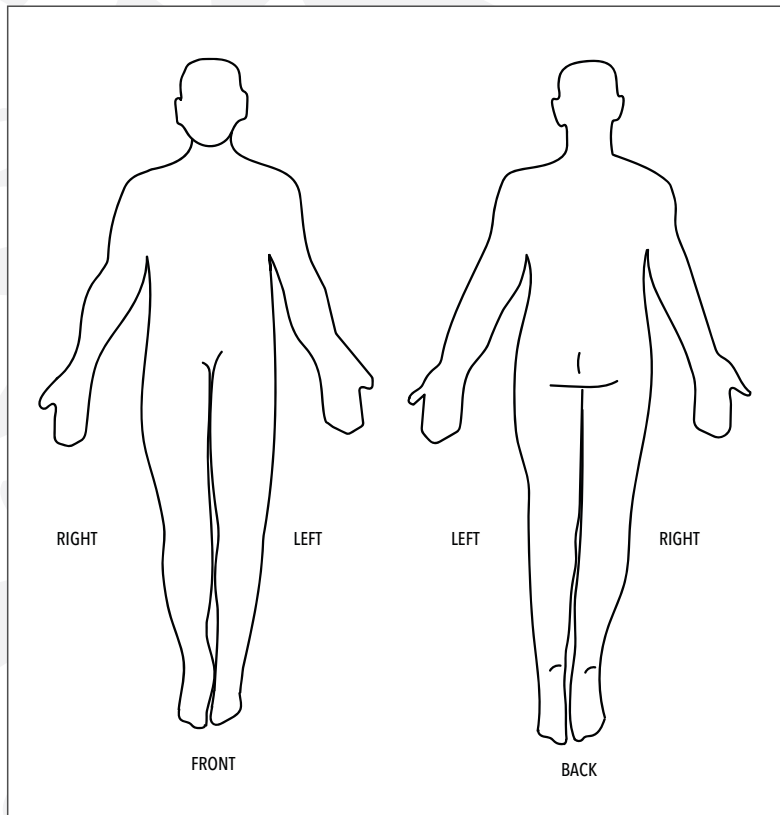
BAY STREET

ORTHOPAEDICS & SPINE

Patient Name _____

Date of Birth _____

Please mark the area where you experience the following sensations using the symbols to the left.



Ache	^^^
Numbness	0000
Pins & Needles	====
Burning	XXXX
Stabbing	////

How bad is your pain? Place an "X" on each of the lines below to indicate your current pain.

How bad is your low back pain?

No Pain 0 ----- 10 Worst Possible

How bad is your leg pain?

No Pain 0 ----- 10 Worst Possible

How bad is your middle back pain?

No Pain 0 ----- 10 Worst Possible

How bad is your neck pain?

No Pain 0 ----- 10 Worst Possible

How bad is your arm pain?

No Pain 0 ----- 10 Worst Possible

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How does each of the following affect your pain?

Sitting	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Standing	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Walking	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Lying Down	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Rising from Chair	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Physical Activity	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Heat	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	<input type="checkbox"/> Don't Know
Cold	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	<input type="checkbox"/> Don't Know
Massage	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	<input type="checkbox"/> Don't Know

We need to know about the treatments you have already received for your current back/neck pain.

If you have had the following, did it make your condition better or worse?

Chiropractic Care	<input type="checkbox"/> Better	<input type="checkbox"/> Worse
Physical Therapy	<input type="checkbox"/> Better	<input type="checkbox"/> Worse
Injections	<input type="checkbox"/> Better	<input type="checkbox"/> Worse
Psychological Consultation	<input type="checkbox"/> Better	<input type="checkbox"/> Worse
Other _____	<input type="checkbox"/> Better	<input type="checkbox"/> Worse

Have you ever had surgery on your back or neck?

Yes No

If YES, complete the following:

Type of Surgery _____

Date _____

Surgeon _____

Did it make your pain Better Worse

Type of Surgery _____

Date _____

Surgeon _____

Did it make your pain Better Worse

Type of Surgery _____

Date _____

Surgeon _____

Did it make your pain Better Worse

Bladder Control (urine)

No Problem Can't Empty Bladder Loss of Urine (accidents)

Bowel Control

No Problem Constipation Loss of Control (accidents)

Do you have any of the following problems?

Is your pain worse at night? Yes No

Does your pain awaken you from sleep? Yes No

Does coughing affect your pain? Yes No

Does your legs tire/hurt if you walk too far? Yes No

If YES, how far can you walk?

Less than 1 block 1-3 blocks more than 3 blocks

Is this relieved by resting your legs? Yes No

Is this relieved by bending forward? Yes No

REVIEW OF SYSTEMS

Patient Name _____

Date of Birth _____

Patient # _____



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ORTHOPAEDICS & SPINE

Do you now or have you had any problems related to the following in the past year?

If you answered Yes to ANY of the above, we recommend seeing your Primary Care Provider or Specialist.

PRIMARY PROVIDER

PHYSICIAN SIGNATURE

DATE

Constitutional Symptoms		
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Eyes		
Blurred Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunologic		
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Neurological		
Tremors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine		
Excessive Thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Too Hot/Cold	<input type="checkbox"/>	<input type="checkbox"/>
Tired/Sluggish	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal		
Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular		
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Integumentary		
Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Boils	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Itch	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal		
Joint Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat/Mouth		
Ear Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problem	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary		
Urine Retention	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Frequency	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory		
Wheezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic/Lymphatic		
Swollen Glands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clotting Problem	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Psychological		
Do you feel anxious?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>

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PATIENT REGISTRATION

Patient Name _____

Date of Birth _____



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ORTHOPAEDICS & SPINE

PATIENT DETAILS		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status
SSN		
Provider	Race	
Primary Care Provider	Hand Dominance	
PHARMACY		
Name	Phone	
CONTACT DETAILS		
Address		
City, State, Zip		
County	Phone	Cell
Email		
OCCUPATION INFORMATION		
Employment Status	Occupation	
Employer Name		
Address		
City, State, Zip		Phone
GUARANTOR DETAILS		
Guarantor	Phone	
Date of Birth	Email	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relation
Address		
City, State, Zip		

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INSURANCE DETAILS		
Primary Insurance	Subscriber Name	
Insurance Plan #	Subscriber DOB	
Group #	Subscriber Relation	
Secondary Insurance	Subscriber Name	
Insurance Plan #	Subscriber DOB	
Group #	Subscriber Relation	
Additional Insurance Information		
EMERGENCY CONTACT		
Name	Relation	Phone
By completing this, you are allowing Bay St. Orthopaedics & Spine to provide information to your emergency contact.		

WORK- OR AUTO-RELATED INJURIES ONLY

Is your injury: Work-related Auto-related? Date of this injury: _____
 Is this claim active? Yes No

BILLING INFORMATION MUST BE PROVIDED PRIOR TO FIRST APPOINTMENT.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:

I AUTHORIZE THE PHYSICIANS OF BAY STREET ORTHOPAEDICS & SPINE TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT; I FURTHER AUTHORIZE PAYMENT OF SURGICAL AND/OR MEDICAL BENEFITS DIRECT TO THE PHYSICIANS OF BAY STREET ORTHOPAEDICS & SPINE. I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE AFTER PAYMENT OF SUCH BENEFITS.

Signature _____ Date _____