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

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 _____

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

PATIENT HISTORY

Patient Name _____

Date of Birth _____

BAY STREET
ORTHOPAEDICS & SPINE

MEDICAL ALLERGIES with REACTIONS

SURGICAL HISTORY

PAST MEDICAL HISTORY

☐ Diabetes ☐ Cancer ☐ Osteoarthritis ☐ Bleeding Disorder ☐ Stroke ☐ Gout
☐ Heart Disease ☐ Blood Clots ☐ Rheumatoid Arthritis ☐ High Blood Pressure ☐ Ulcers ☐ Other

HOBBIES

SMOKING STATUS

☐ Never ☐ Former/Date Quit ☐ Current/Packs per day

FAMILY MEDICAL HISTORY

HEART DISEASE	☐ Mother	☐ Father	☐ Brother	☐ Sister
DIABETES	☐ Mother	☐ Father	☐ Brother	☐ Sister
CANCER	☐ Mother	☐ Father	☐ Brother	☐ Sister
ARTHRITIS	☐ Mother	☐ Father	☐ Brother	☐ Sister
OTHER	☐ Mother	☐ Father	☐ Brother	☐ 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

BAY STREET
ORTHOPAEDICS & SPINE

MEDICATIONS		
Name	Dosage	Reason for Taking

Signature Date

Print Name

How does each of the following affect your pain?

Sitting	☐ Better	☐ Worse	☐ No Change	
Standing	☐ Better	☐ Worse	☐ No Change	
Walking	☐ Better	☐ Worse	☐ No Change	
Lying Down	☐ Better	☐ Worse	☐ No Change	
Rising from Chair	☐ Better	☐ Worse	☐ No Change	
Physical Activity	☐ Better	☐ Worse	☐ No Change	
Heat	☐ Better	☐ Worse	☐ No Change	☐ Don't Know
Cold	☐ Better	☐ Worse	☐ No Change	☐ Don't Know
Massage	☐ Better	☐ Worse	☐ No Change	☐ Don't Know

BAY STREET
ORTHOPAEDICS & SPINE

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	☐ Better	☐ Worse
Physical Therapy	☐ Better	☐ Worse
Injections	☐ Better	☐ Worse
Psychological Consultation	☐ Better	☐ Worse
Other _____	☐ Better	☐ 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 #

BAY STREET
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	☐ Yes	☐ No
Chills	☐	☐
Headache	☐	☐
Other	☐	☐
Eyes		
Blurred Vision	☐ Yes	☐ No
Double Vision	☐	☐
Pain	☐	☐
Other	☐	☐
Allergic/Immunologic		
Hay Fever	☐ Yes	☐ No
Drug Allergies	☐	☐
Other	☐	☐
Neurological		
Tremors	☐ Yes	☐ No
Dizzy Spells	☐	☐
Numbness/Tingling	☐	☐
Other	☐	☐
Endocrine		
Excessive Thirst	☐ Yes	☐ No
Too Hot/Cold	☐	☐
Tired/Sluggish	☐	☐
Other	☐	☐
Gastrointestinal		
Abdominal Pain	☐ Yes	☐ No
Nausea/Vomiting	☐	☐
Indigestion/Heartburn	☐	☐
Other	☐	☐
Cardiovascular		
Chest Pain	☐ Yes	☐ No
Varicose Veins	☐	☐
High Blood Pressure	☐	☐
Other	☐	☐

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

PATIENT REGISTRATION

Patient Name

Date of Birth

BAY STREET
ORTHOPAEDICS & SPINE

PATIENT DETAILS		
Gender ☐ Male ☐ 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 ☐ Male ☐ Female	Relation	
Address		
City, State, Zip		

BAY STREET
ORTHOPAEDICS & SPINE

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 _____