2300 Haggerty, Suite 1110
West Bloomfield, MI 48323
Phone: (248) 669-2000
Fax: (248) 669-2110

28080 Grand River Ave, Suite 208N
Farmington Hills, MI 48336
Phone: (248) 669-2000
Fax: (248) 669-2110

Registration

Is your injury work related? **Yes____ No____** ***Is your injury auto accident related?*** **Yes____ No____**

If so, when was the Date Of Injury: _____

PATIENT INFORMATION:

Social Security #: _____ **First Name:** _____ **Last Name:** _____
Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Date of Birth: _____ **Marital Status**: _____ **Gender:** _____
Ethnicity: _____ **Race:** _____ **Language**: _____
Home Phone: _____ **Cell Phone:** _____
Email Address: _____
Occupation: _____ **Employer Name:** _____

How did you hear of us? _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

PHYSICIAN & PHARMACY INFORMATION:

Primary Care Doctor: _____ **Phone #:** _____
Address: _____ **Fax #:** _____
City: _____ **State:** _____ **Zip Code:**_____
Pharmacy Name: _____ **Address:** _____
Phone #: _____ **Fax #:** _____

INSURANCE INFORMATION:

Primary Insurance: _____
Policy #: _____ **Group #:** _____
Subscriber Name: _____ **Date of Birth:** _____

Secondary Insurance: _____
Policy #: _____ **Group #:** _____
Subscriber Name: _____ **Date of Birth:** _____

Legal Guardian or Power of Attorney *if applicable*:
First Name: _____ **Last Name:** _____ **Date of Birth:** _____
Relation to Patient: _____ **Gender:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:**_____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

CONSENT FOR TREATMENT, AUTHORIZATION OF BENEFITS & INFORMATION RELEASE:

I hereby authorize those medical and/or surgical benefits otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize Ronald S. Lederman, M.D., P.L.L.C. and my physician to release any information required by my insurance company to process claims. I am presenting myself to Ronald S Lederman, MD, PLLC, for evaluation, diagnosis, and/or treatment of a medical condition. I give consent and authorize my provider to order and/or perform all exams, tests, procedures, and any other care deemed necessary or advisable for the evaluation, diagnosis, and treatment of this medical condition. This consent is valid for each visit made to the office, unless and until revoked in writing.

_____ _____

Patient/Guardian Signature Date

Revised 07/28/17 KG

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Consent to Treat Minor

Child's Full Name: _____ DOB: _____

RESPONSIBLE PARENT OF MINOR CHILD INFORMATION:

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Gender: _____ Social Security #:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Email Address:_____

Occupation:_____ Employer Name:_____

Employer Address:_____

City: _____ State: _____ Zip Code: _____

AUTHORIZATION OF BENEFITS & INFORMATION RELEASE:

I hereby authorize those medical and/or surgical benefits otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize Ronald S. Lederman, M.D., P.L.L.C. and my physician to release any information required by my insurance company to process claims.

_____ _____

Patient/Guardian Signature Date

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New Problem / Injury Form

Is your injury work related? Yes____ No____ ***Is your injury auto accident related?*** Yes____ No____

If so, when was the Date Of Injury: _____

Patient Name: _____Date:_____

I. What are you being seen for today? _____

II. Which side is affected? Right ☐ Left ☐ Bilateral ☐

III. Date of injury or start of pain: _____
How did the pain occur? Injury ☐ Chronic ☐ Spontaneous ☐
If an injury, how did it occur? _____
Where did it occur? _____
Is this work related? Yes ☐ No ☐ Last day of work? _____
Is this the result of a motor vehicle accident? Yes ☐ No ☐ Date of Accident: _____

IV. Pain Description
Quality of your pain? None ☐ Mild ☐ Moderate ☐ Severe ☐
Type of pain? Sharp ☐ Dull ☐ Other ☐ _____
Have you seen another physician for this injury? Yes ☐ No ☐
If yes, Who and When? _____
What treatments have you tried? Nothing ☐ P.T. ☐ Brace ☐ Injections ☐ Surgeries ☐ Icing ☐
Other ☐ _____ If surgery, Please specify: _____

Pain level: (Please enter 1-10) 1-10 (1-3 = Mild) (4-7 = Moderate) (8-10 = Severe)

Have you had any testing? MRI ☐ EMG/NCS ☐ Bone/CAT Scan ☐
If yes, where and when? _____

Auto Insurance

Date of Accident: _____ Carrier Name: _____

Claim Number: _____ Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

Do you have an attorney for this claim? Yes ☐ No ☐

Attorney Name: _____ Attorney Phone: _____

Workman's Compensation Insurance

Date of Injury: _____ Carrier Name: _____

Claim Number: _____ Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

Employer: _____ Employer Phone: _____

Do you have an attorney for this claim? Yes ☐ No ☐

Attorney Name: _____ Attorney Phone: _____

Patient/Guardian Signature _____ Date _____

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Medication List

Patient Name: _____ **Date:**_____

Does patient have: **Type 1 Diabetes** ☐ **or** **Type 2 Diabetes** ☐

Daily Medications: Yes No

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

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Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Drug Name: _____Dosage_____Freq_____

Patient/Guardian Signature _____ **Date** _____

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Office and Financial Policies

Welcome and thank you for choosing Ronald S. Lederman, M.D., P.L.L.C. for your orthopaedic care. We are committed to providing you with the highest quality medical care, in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding at the time of your visit.

The patient is responsible for knowing their insurance benefit coverage and whether a referral is needed for specialist visits. We will gladly file your insurance claim on your behalf. We allow 30 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefits, deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or reasonable and customary charges, other than to supply factual information when necessary. You are responsible for the timely payment of your account by either yourself or your insurance company. It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you will have the referral *in hand* at the time of your appointment. We accept faxed referrals (F:248.669.2110). If we do not have your referral on the appointment date, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

Self-Pay Patients: New Patients presenting without insurance are required to pre-pay a deposit of $200.00. Depending on services rendered, the patient will receive a same day refund for any overpayment or will receive a balance due bill upon check-out.

Check-In: New patients should arrive 15 minutes prior to appointment time to complete paperwork. Bring your current insurance card with you on EACH VISIT. Without the insurance card we will be unable to file your insurance and you will be responsible for the charges for the day. On follow-up visits you will be asked to verify demographic and insurance information so that our records remain up-to-date.

Check-Out: Please be prepared to pay for the current visit as well as any past balances on your account. Co-pays, deductibles or fees for non-covered services will be required at the time of service. For your convenience, we take cash, check, MasterCard, Visa, American Express and Discover.

Late Arrivals: We do our best to keep to the schedule. When a patient arrives late it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time you will be rescheduled so that other patients are not inconvenienced.

No Shows and Late Cancellations: We require a 24-hour advance notice if you must cancel your appointment. For your convenience, we will call you 48 hours prior to your appointment. If you cancel on the same day as your appointment you will be considered a NO SHOW for that visit. Each patient is allowed one NO SHOW without penalty. The second NO SHOW will result in a $50.00 charge to your account.

Non-Covered Services: An "Insurance Waiver" may be required to acknowledge understanding of your responsibility for paying for non-covered services. There are procedures/supplies that are considered by Medicare and private insurers as non-covered. If you are coming in for a non-covered service, please be prepared to pay for the service in full.

Telephone Communications: I give my express permission to Ronald S. Lederman MD PLLC and its Affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for my landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice, or text message.

Minors: The parent(s) or guardian (s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be rendered.

I have read, understand and agree to the above office and financial policies. I hereby attest that I agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name: _____ Date of Birth: _____

Responsible Person's Signature: _____ Date: _____

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Privacy Practices Acknowledgement and Consent Form

Please initial each relevant box.

I have received your Notice of Privacy Practice and/or I have been provided an opportunity to review it.

I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(_____) _____ - _____ Home ☐ / Office ☐ / Cell ☐ / Other: ☐ _____

(_____) _____ - _____ Home ☐ / Office ☐ / Cell ☐ / Other: ☐ _____

(_____) _____ - _____ Home ☐ / Office ☐ / Cell ☐ / Other: ☐ _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

I agree that my PHI may be shared with my spouse.

I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

_____ _____

I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Ronald S Lederman, MD, PLLC.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

_____ _____
Patient Name (Last, first, middle initial) Date

_____ _____
Parent/Guardian if the patient is a minor (under 18 years of age), the responsible parent/guardian must sign Relationship to Patient