



Welcome to MedQuan Sports Medicine! In our effort to provide you with the best possible care, we encourage you to play an active role by asking questions so informed decisions can be made.

Below are forms required for patients seeking an appointment at MedQuan Sports Medicine. All forms must be received at least one day prior to the scheduled appointment.

- Patient Information Sheet
- Health History Questionnaire
- Payment and Billing Policy & Procedures
- Missed Appointment Policy
- Disclosure of Information for Reimbursement and Assignment of Benefits / Communication of Your Protected Health Information
- Release of Medical Information Consent
- HIPAA Privacy Act

At least one business day prior to your scheduled appointment, please fax, mail or drop off your completed paperwork to us. This will allow us to enter your medical information into the electronic medical record so that we will be better prepared for your visit. **Please note: if we have not received your completed paperwork prior to your appointment, we will not be able to see you for your appointment.**

We work hard to see our patients in a timely fashion. However, situations can arise resulting in a longer wait than either of us would like. Please be assured that we will always see you as soon as possible and provide you with the necessary time for your exam while answering questions you may have with the overriding goal of increasing your understanding and comfort.

Fax completed and signed forms to 810-220-8669.

OR

Mail completed and signed forms to:
MedQuan Sports Medicine
Attn: Receptionist
110 E. Main St.
Brighton, MI 48116

OR

Drop them off at MedQuan Sports Medicine.

Please be sure to bring the following with you to your appointment:

- Insurance card(s) and all pertinent insurance identification
- Driver's License
- Referral slip, if needed
- Loose fitting clothes

Please be advised that **YOU ARE RESPONSIBLE** for knowing and understanding the policies and benefits of your insurance plan before your appointment.

Once again, welcome!



PATIENT INFORMATION SHEET

Date Patient's Full Name:
(Name if you go by something different than stated above)
Date of Birth: SS#: Sex: M / F Marital Status: S M D W
Patient's Address:
City: State: ZIP:
Patient's Home Phone: Mobile:
Patient's Employer: Work #:
If student or minor, Parent/Guardian's Name:
In case of Emergency, Notify: Phone:

Primary Physician Name:
Address:
City: State: ZIP:
Phone:

How were you referred to us?

Person Responsible for Payment: Relationship to Patient:
Address, if different from patient:
City: State: ZIP:
Home Phone: Work Phone:

Primary Health Insurance:
Policy/Contract #: Group #: Co-pay Amount: \$
Card holder's Name: Date of Birth:
Card holder's Address:
Patient's relationship to Card holder: Card Holder's Employer:

Secondary Health Insurance:
Policy/Contract #: Group #: Co-pay Amount: \$
Card holder's Name: Date of Birth:
Card holder's Address:
Patient's relationship to Card holder: Card Holder's Employer:

IS THIS A WORK-RELATED INJURY? YES NO
W/C AUTH #: DATE OF INJURY:

IS THIS AN AUTO ACCIDENT RELATED INJURY: YES NO
CLAIM #: DATE OF INJURY:

I certify that the above information is my personal information and has not been fraudulently derived.

Patients Name Patient's/Guardian's Signature (if underage)

Witness Signature Date



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ **Sex:** M F **DOB:** _____

Marital Status: Single Married Separated Divorced Widowed

Number of Children: _____

Personal Health History

Allergies to Medications/Foods/Insects:

Name of Allergen	Date of Onset	Reaction You Had

Medical History:

Diagnosis	Date	Location

List your prescribed drugs and over-the-counter drugs (i.e. vitamins, supplements)

Name of drug	Start Date	Strength	Frequency Taken

List Hospitalizations

Year	Reason	Hospital Name

Surgeries

Year	Surgery	Location

Past Medical History

	NO	YES	Describe
Allergies			
Asthma			
Blood Clots			
Blood Disorders			
Breast Cancer			
Colon Cancer			
Other Cancers			
Diabetes			
Depression			
Drug/Alcohol Addiction			
Eating Disorders			
Fractures			
Glaucoma			
Heart Disease (arteriosclerosis)			
Heart Attack (MI)			
High Blood Pressure (hypertension)			
High Cholesterol			
Irritable Bowel (IBS)			
Kidney Disease			
Learning Disabilities			
Liver Disease			
Mental Illness			
Osteoporosis			
Seizures			
Sprains			
Stroke			
Thyroid Disease			
Other			

Immunizations

	Date
Hepatitis B Series	
MMR	
Tetanus	
Chickenpox	
Flu Shot	
Pneumonia Shot	
Other	

Family History

	NO	YES	Describe
Asthma			
Blood Clots			
Bleeding Disorders			
Breast Cancer			
Colon Cancer			
Other Cancers			
Depression			
Diabetes			
Drug/Alcohol Addiction			
Glaucoma			
Heart Attack			
Heart Disease			
Heart Surgery			
High Blood Pressure			
Kidney Disease			
Liver Disease			
Mental Illness			
Obesity			
Osteoporosis			
Seizures			
Stroke			
Suicide			
Thyroid Disease			
Other			

Activity Level: Very Active Active Mild Sedentary

Nutrition: Good Poor

5-6 Fruits-Vegetables/Day? No Yes

Water intake cups/day: 1 2 4 6 8

Amount of calcium intake/day: 500mg 1,000mg 1,200mg 1,500mg

Tobacco: Do you use tobacco? No Yes

Amount:

Cigarettes: packs/day____ Chew: #/day____ Pipe: #/day____ Cigars: #/day____

of years____

When did you quit? (If applicable) Year quit ____

of years____

Cigarettes: packs/day/yr____ Chew: #/day/yr____ Pipe: #/day/yr____ Cigars: #/day/yr____

Alcohol: Do you drink alcohol? No Yes

How often do you drink? Daily Weekly Socially

What do you drink? Beer Wine Hard Liquor

Drugs: Do you use recreational or street drugs? No Yes

If so, what kind? _____

Caffeine Intake: Do you consume caffeine? No Yes

Amount/Day:

8-12 oz 12-24 oz 24-48 oz >48 oz

I certify that the above information (pages 3-6 of this document) is accurate.

Patients Name

Patient's/Guardian's Signature (if underage)

Witness Signature

Date



PAYMENT AND BILLING POLICY & PROCEDURES

Please take a few moments to review the following information concerning the payment and billing procedures of the services you will receive in our office. We have provided this information for you because, ultimately, you are responsible for all charges and payments for services rendered and knowing and understanding the policies and benefits of your insurance plan.

It is the responsibility of the patient to provide MedQuan Sports Medicine with the most up-to-date insurance information. Our physicians participate with many insurance plans and preferred provider networks. Please check with your insurance carrier to insure the physician of your choice is a participating member of your medical plan. As a courtesy to you, we will submit a claim for all physician services to your insurance company. Please be advised that unreported changes in medical insurance could result in billing delays and errors.

Co-payments and/or deductibles are the responsibility of the patient and will be expected at the time of service. For your convenience, we accept cash, personal check, VISA or MasterCard.

Patients who are self-pay or those who incur services that not covered by their insurance are expected to pay in full at time of service.

Billing statements will be mailed for any denied or unpaid claims. The statement will reflect all charges not covered by your insurance company and any payments received. Payment is expected within 30 days. If no payment has been received within this time frame, a second statement will be sent. In the event that a third and final statement is required, additional collection steps will be taken. At this time, a pre-collection letter will be sent and your physician will be notified as to the status of your delinquent account. Your failure to make payment may result in turning over your account to an outside collection agency and discharging you from the practice wherein notification will be made via certified mail.

Thank you for taking the time to read this important information.

I have read and agree to the above MedQuan Sports Medicine Payment and Billing Policy and Procedure.

Patients Name

Patient's/Guardian's Signature (if underage)

Witness Signature

Date



MISSED APPOINTMENT POLICY

In order to provide quality care to our patients, improve access to our physicians, and minimize frustrations in getting timely appointments, our office has adopted the following policy regarding missed appointments.

I understand that if I should fail to keep a scheduled appointment three (3) times in a twelve (12) month period, I will be discharged from the practice. It will then be necessary for me to make arrangements to receive my medical care elsewhere.

I further understand the procedure works as follows:

- If I cannot attend a scheduled appointment, the office needs to be contacted no later than the business day prior to the scheduled appointment to cancel the appointment and avoid a “missed appointment.”
- A fee may be charged for each “missed appointment.”
- After one appointment is missed, a notification will be sent to me indicating a scheduled appointment has been missed.
- Upon missing a third scheduled appointment, a certified letter will be sent to me indicating that I now have thirty (30) days to arrange medical care elsewhere. I further understand that MedQuan Sports Medicine will continue to provide medical care during that period on emergency basis only. Thirty days from the receipt of the discharge letter, I understand that I will be removed from this office’s active patient list.
- Parents and/or legal guardians will be held responsible for the appointments of minor children.

I have read the “Missed Appointment Policy” in its entirety and fully understand that the above information relates to me and my family members.

Patients Name

Patient’s/Guardian’s Signature (if underage)

Witness Signature

Date



DISCLOSURE OF INFORMATION FOR REIMBURSEMENT AND ASSIGNMENT OF BENEFITS

I authorize MedQuan Sports Medicine to disclose protected health information to my insurance carrier or other third party responsible for my bill as required in order to receive reimbursement for services provided. This information may include mental health treatment, genetic testing, and information about serious communicable diseases, such as STDs, hepatitis, HIV, and AIDS.

I authorize and request assignment of benefits to be paid directly to MedQuan Sports Medicine. I acknowledge and agree to pay any unpaid balances not covered by my insurance policy, including deductibles and co-payments.

Patients Name

Patient's/Guardian's Signature (if underage)

Date of Birth

Witness Signature

Date



COMMUNICATION OF YOUR PROTECTED HEALTH INFORMATION

The following information will assist us in communicating with you about your care while protecting your confidentiality. Preferred method of contact:

- Home phone: _____ Work phone: _____
- Cell Phone: _____ Mail: _____
- Other: _____

If you are unavailable, may we leave a message for you to return our call on your home phone? Yes No
 On your work phone? Yes No
 On your cell phone? Yes No

If you are unavailable, and you want us to speak with another individual about your care, please list their name, relationship to you, and phone number: _____

Patients Name

Patient's/Guardian's Signature (if underage)

Witness Signature

Date



RELEASE OF MEDICAL INFORMATION CONSENT FORM

MedQuan Sports Medicine may release any medical information to the following persons. If there are no names written in this section, we WILL NOT be able to release any information to anyone other than you.

Name Relationship

Name Relationship

Name Relationship

It is MY RESPONSIBILITY to notify MedQuan Sports Medicine of any changes to the above instructions.

Patients Name

Patient's/Guardian's Signature

Witness Signature

Date



HIPAA PRIVACY ACT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Official for:
MedQuan Sports Medicine
(810) 220-8600

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At MedQuan Sports Medicine, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit MedQuan Sports Medicine, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information,

and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of MedQuan Sports Medicine, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

MedQuan Sports Medicine is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

MedQuan Sports Medicine, reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of How MedQuan Sports Medicine May Use or Disclose Your Health Information:

For Treatment: MedQuan Sports Medicine may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: MedQuan Sports Medicine, may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: MedQuan Sports Medicine, may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification, or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: MedQuan Sports Medicine, may use and disclose information about you as required by law. For example, MedQuan Sports Medicine, may disclose information for the following purposes:

- 1) for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; 2) and
- 3) to assist law enforcement officials in their law enforcement duties.

