Specialists in Spine Surgery
14555 Levan Rd, Ste 310 Livonia, MI 48154

Miles L. Singer, DO, FACOS, FAOAO
Stanley S. Lee, MD

Commerce • Dearborn
Farmington Hills
Garden City • Livonia

Office: 734-70-SPINE
Fax: 734-70-SPINE
www.spinedocs.info

Welcome to Our Office

HIPAA

Office hours:
Office hours are from 9 a.m. to 5 p.m. Monday through Thursday, and 9 a.m. to 12 p.m. on Friday. Office visits are by appointment only.

Telephone calls:
Telephone calls will be answered during regular business hours. If you call after hours you will have the opportunity to leave a voice message.

Fees and Payment:
Office visit payment and co-pays are expected at the time of service. There is a $25.00 fee for copying medical records plus retrieval charges, if necessary. For your convenience, the office does accept cash, checks, Master Card, and Visa.

Insurance:
Please understand that your insurance policy is a contract between you and your insurance company. Claims will be submitted to your insurance carrier as long as you provide the necessary information. Due to the many changes in insurance policies, it is no longer possible to interpret each individual policy. It is your responsibility to no your individual coverage and to supply us with this information. If incorrect information causes a delay in billing, he may be held responsible for the cost of your care and treatment.

Forms and Prescriptions:
Our office will complete one insurance form per claim at no charge. The completion of forms is done at the discretion of the doctor and should be discussed with him at the time of your visit. There will be a fee for any additional insurance forms.

If you are requesting any prescriptions, please do so at the time of her visit. Subsequent refills may be requested via phone **during office hours only**. The information will then be submitted for approval, and he will be notified once the medication has been called to the pharmacy. Again, the filling of prescriptions and refills are done at the discretion of the physician.

If you have any questions or concerns, please do not hesitate to call the office.

Your signature below verifies that you have read and understand the above information.

Signature:_____

Email:_____

Date:_____

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HIPAA

TO ALL PATIENTS OF DR MILES SINGER, D.O

RE: **NO CALL/ NO SHOW POLICY/FEE**

Dear patients,

Effective March 1, 2005. Dr Singer will *charge a $50.00 fee for* anyone that does not provide 24 hours' notice to cancel their appointment. This fee will be payable prior to your next scheduled visit and will be billed directly to *your* home address. This policy is being put into effect due to the recent increase in patients not showing for their scheduled appointments, When patients do not show for their scheduled appointments this decreases the amount of care we can provide for other patients in need. That time is set aside for you, and if you are unable to make that time, someone else could be scheduled in place.

If you have a total of three no call/no shows, your care as a patient will be suspended and you will be provided with a list of other physicians you may choose from to further visit and be treated. By signingg below, I understand this new policy of Miles L Singer, DO, PLLC and understand I am responsible for payment of $50.00 if I do not provide proper notice of canceling my scheduled appointment.

_____
Printed Name

_____ _____
Signature of patient Date

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DISABILITY / MEDICAL FORMS

Practice Policy for forms including disability, life, supplemental insurance, extension of disability, or any form pertaining to time off work is as follows:

1. All forms must be turned into front desk receptionist at time of check in.

2. There is a $10.00 charge for each form to be filled out.

3. Due to HIPAA regulations we are unable to fax any form unless the proper paperwork has been filled out by the requesting company. All forms must be either mailed to the company, the patient, or be picked up in the office by the patient or an authorized representative.

4. There will be up to a 7 – 10 business day processing period for all forms. This allows time for preparing the form, receiving approval and obtaining a signature from the physician.

I have read and understand the above information regarding disability/medical forms.

_____ _____

Patient Signature Date

Patient Name: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was ***OFFERED*** a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understood the Notice.

_____ _____
Patient Name Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

"GOOD FAITH REPORT"

Patient Name: _____ Date: _____
First Name Last Name

The patient presented for treatment on this date and was provided with a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained because:

☐ Patient refused to sign

☐ Patient was unable to sign because: _____

☐ There was a medical emergency and the practice will attempt to obtain acknowledgement at the next available opportunity.

☐ Other: _____

Signature of employee completing this form: _____

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Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, _____ authorize Miles L Singer, DO, PLLC to release and obtain my private health information
Print Name
to/from (check all that applies):

☐ My spouse/partner — Name of spouse: _____

☐ My primary care physician/staff — Name of Doctor: _____

☐ My Pharmacy — Name of Pharmacy: _____

☐ My parent/child(ren) — Name(d): _____

☐ My personal representative — Name of representative: _____

☐ Other — Name: _____

☐ Other — Name: _____

☐ None of the above. May our office leave a message on your machine? ☐ Yes ☐ No

Are there any restrictions on PHI to be disclosed ☐ Yes ☐ No
If yes:

_____

_____

_____

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Miles L Singer, DO, PLLC. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention *Privacy Officer at, SSS, 2300 Haggerty Road, Ste 2100, W. Bloomfield, MI 48323*. I understand that my revocation will not affect any actions taken by Specialists in Spine Surgery, PLLC prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed. At which time this authorization to obtain and release this protected health information expires.

_____ _____
Patient Signature or Authorized Representative — Date

_____
Patient Name Printed

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Registration Form/ Insurance Documentation

Patient Name: _____ **Date of Birth:**_____ **Gender:** ☐ **M** ☐ **F**

Address: _____ **Home/Cell:** _____ **Age:** _____

Patient's Employer: _____ **Work Phone:** _____

☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Emergency Contact: _____ **Phone:** _____

***Please do NOT use your Home Phone number for the Emergency Contact!!*

Family Physician/Internist: _____ **Phone:** _____

Did your Family Physician/Internist refer you to us? ☐ **YES** ☐ **NO**

In NO, please list referring Physician: _____

Pharmacy: _____ **Phone:** _____

Responsible Party Information (*If other than Patient)*

Name: _____ **Social Security #:** _____

Address *(if different):* _____

Relationship to Patient: _____ **Employer:** _____ **Date of Birth:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE Subscriber Name: _____ **Date of Birth:** _____

SSN: _____ **Insured's Employer:** _____ **Retired:** ☐ **YES** ☐ **NO**

SECONDARY INSURANCE Subscriber Name: _____ **Date of Birth:** _____

SSN: _____ **Insured's Employer:** _____ **Retired:** ☐ **YES** ☐ **NO**

Do you believe your condition is WORK related? ☐ **YES** ☐ **NO** ☐ **?**

Have you reported your condition to your employer? ☐ **YES** ☐ **NO** ☐ **N/A**

Is there an active claim for this condition? ☐ **YES** ☐ **NO**

Is your injury the result of an *AUTO* related injury? ☐ **YES** ☐ **NO**

Have you reported the accident and injury to your Auto Insurance Company? ☐ **YES** ☐ **NO**

Auto Insurance Company: _____

Claim Number: _____ **Adjuster's Phone #:** _____

Could this injury result in a LIABILITY? ☐ **YES** ☐ **NO**

Injury Location: _____ **Contact Person:** _____ **Phone#:** _____

You MUST provide us with the insurance information at the time of your appointment for any WORK, AUTO and/or LIABILITY injury in order to be seen. According to insurance guidelines which we must follow, we may NOT bill health insurance for these types of injuries, unless a special coordination of benefits exists with your health insurance. *

I AUTHORIZE Miles L. Singer, DO, PLLC TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO MILES L SINGER, DO, PLLC FOR SERVICES RENDERED. I AGREE TO PAY MY COPAYS, DEDUCTIBLES AND ANY BALANCE THAT IS DENIED OR IN DISPUTE BY MY INSURANCE COMPANY.

SIGNATURE _____ **DATE:** _____

(PATIENT, PARENT, OR RESPONSIBLE PARTY)

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Please list **ALL Medications** WITH Dosages (Prescription, Vitamins, Herbal, etc.): ☐**NONE**

Please list **ALL Allergies** to any Medications, Latex, Tapes, Etc.: ☐**NONE**

Please list **ALL types of Surgeries** you have had & the Year- *Including which body area* (ie Right Knee Arthroscopy): ☐**NONE**

Please Circle "Y" or "N" for any medical conditions YOU suffer from:

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Polio	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Scoliosis	Y	N
Bladder/Prostate Problems	Y	N	Frequent Headache/Migraine	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	Kidney Disorder	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease/Jaundice	Y	N	Thyroid Disorder	Y	N
Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Weakness or Paralysis	Y	N

Family History –

Please Circle "Y" or "N" for any conditions YOUR FAMILY suffers from:

Anemia	Y	N	Emphysema	Y	N	Heart Problems	Y	N	Polio	Y	N
Arthritis	Y	N	Epilepsy	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Fibromyalgia	Y	N	Hiatal Hernia	Y	N	Scoliosis	Y	N
Bladder/Prostate Problems	Y	N	Frequent Headache/Migraine	Y	N	High Blood Pressure	Y	N	Seizures	Y	N
Blood Clots	Y	N	Gall Bladder	Y	N	Kidney Disorder	Y	N	Stroke	Y	N
Blood Transfusion	Y	N	Head Injury	Y	N	Liver Disease/Jaundice	Y	N	Thyroid Disorder	Y	N
Cancer	Y	N	Hearing Problems	Y	N	Meningitis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Heart Attack	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N
	Y	N	Heart Catheterizations	Y	N	Pneumonia	Y	N	Weakness or Paralysis	Y	N

The above information is completed to the best of my knowledge

Patient Signature **Date**

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Medical History for _____ fill in Name

We require that you specify whether or not you believe your medical problem IS or IS NOT related to a specific injury, so that your insurance claim for medical services rendered may be properly processed.

HISTORY OF PRESENTING ILLNESS:

☐ **My medical problem *IS NOT* related to an Injury**
What area of the body is to be examined today? _____ *(Be Specific – i.e. right knee)*
When **did your symptoms begin? _____**
or
☐ **My medical problem *IS* related to an Injury**

What **area of the body is to be examined today? _____ (BE SPECIFIC)**
When **did your injury or onset of symptoms begin?** *Date of Injury:* _____/_____/_____
Where **did your injury occur?**

☐ **Home**
☐ **Work** - ***if yes,*** *Have you reported your condition to your employer?* ☐ **YES** ☐ **NO**
☐ **MVA(Auto)** ***if yes****, Have you reported the accident and injury to your Auto Insurance Company?*
☐ **Other: _____ (Please be specific)**
IF yes, Did *your injury occur somewhere other than your own property?* ☐**YES** ☐ **NO**
Is your injury related to a work or a motor vehicle accident? ☐**YES** ☐ **NO**

Occupation: _____ ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired

Are you currently working? ☐ YES ☐ NO-Last day: _____ ☐ Unemployed ☐ Disabled

- Reason not working:_____

HEALTH HISTORY:

Hand Dominance: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS
Height _____ Weight _____ Age:__ Date of Birth: _____

Do you smoke? ☐YES ☐NO *How Much?* _____ Per Day *For How Long?* _____

Have you quit? ☐ YES ☐ NO *When?* _____

Do you Drink Alcohol? ☐ YES ☐ NO

How much? ☐ Socially ☐ Weekly ☐ Daily ☐ Monthly ☐ Rarely

Is there any chance you could be pregnant? ☐ YES ☐ NO Date of Last Menstrual Period: _____

Have you been tested for HIV/AIDS? ☐YES ☐ NO

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Review of Systems

Do you now or have you recently had any problems related to the following systems? Circle YES or NO. If you mark yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Name: _____ **Date:**

Allergic/Immunological:
Hay Fever **Y** **N**
Drug Allergies **Y** **N**
Allergic seizure **Y** **N**
Other: _____

Cardiovascular:
Chest pain **Y** **N**
Varicose veins **Y** **N**
Leg swelling **Y** **N**
Irregular Heartbeat **Y** **N**
Other: _____

Constitutional Symptoms:
Fever **Y** **N**
Chills **Y** **N**
Headache **Y** **N**
Other: _____

Ear/Nose/Throat/Mouth:
Ear Problems **Y** **N**
Sore Throat **Y** **N**
Sinus Problem **Y** **N**
Other: _____

Endocrine:
Excessive Thirst **Y** **N**
Too hot/cold **Y** **N**
Tired/Sluggish **Y** **N**
Other: _____

Eyes:
Blurred Vision **Y** **N**
Double Vision **Y** **N**
Pain **Y** **N**
Other: _____

Gastrointestinal:
Abdominal pain **Y** **N**
Nausea/Vomiting **Y** **N**
Indigestion/Heartburn **Y** **N**
Other: _____

Genitourinary:
Urine retention **Y** **N**
Painful urination **Y** **N**
Urinary frequency **Y** **N**
Other: _____

Hematological/Lymphatic:
Swollen glands **Y** **N**
Blood clotting problem **Y** **N**
Other: _____

Integumentary:
Skin rash **Y** **N**
Boils **Y** **N**
Persistent itch **Y** **N**
Other: _____

Musculoskeletal:
Joint Pain **Y** **N**
Neck Pain **Y** **N**
Back Pain **Y** **N**
Other: _____

Neurological:
Seizures **Y** **N**
Tremors **Y** **N**
Dizzy Spells **Y** **N**
Numbness/Tingling **Y** **N**
Other: _____

Psychological:
Do you suffer from depression? **Y** **N**
Do you feel severely anxious or nervous? **Y** **N**

Other: _____

Respiratory:
Wheezing **Y** **N**
Frequent cough **Y** **N**
Shortness of breath **Y** **N**
Other: _____

Physician Signature: _____ Date: _____

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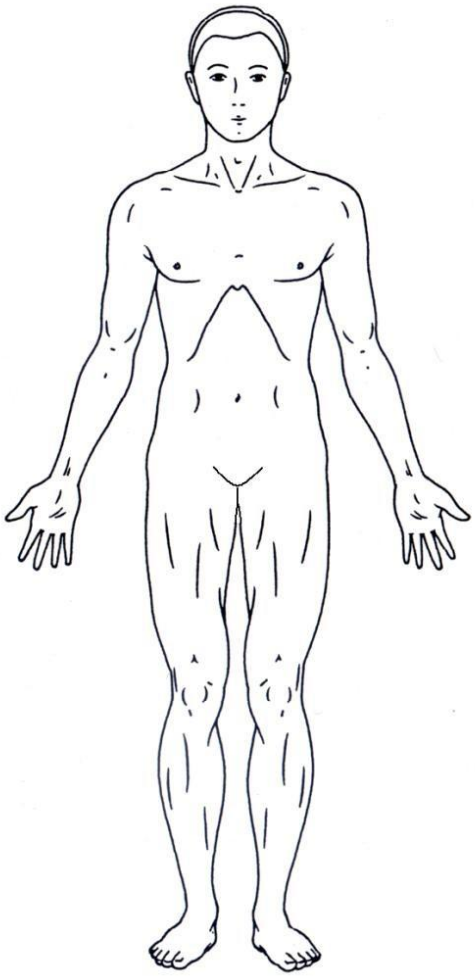
Patient Health History

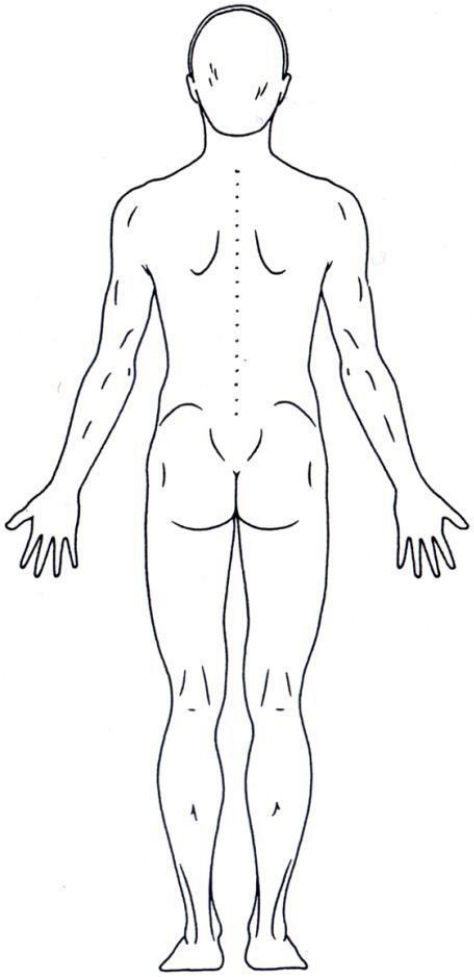
Mark the area on the diagram where you have:

Ache	Numbness	Pins & Needles	Stabbing	Burning	Shooting
^^^^^^^	000000	XXXXXX	//////	######	ΔΔΔΔΔ

FRONT SIDE **BACK SIDE**

Right Side **Left** **Left** **Right Side**





How bad is the pain on a 0 – 10 scale?

0 1 2 3 4 5 6 7 8 9 10

MILD **WORST**

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PLEASE READ CAREFULLY

AGREEMENT AS TO RESOLTUION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____. (***insert name of patient or guardian)***
"Physician" shall be understood to mean Miles L Singer, DO, Miles L Singer, DO, PLLC, and Specialists in Spine Surgery.
I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.
Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Academy of Osteopathic Orthopedic Surgeons, American Academy of Orthopedic Surgeons, North American Spine Society
I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Academy of Osteopathic Orthopedic Surgeons, American Academy of Orthopedic Surgeons, and North American Spine Society and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.
In further consideration, Physician also agrees to exactly the same above-referenced stipulations.
Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.
Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.
Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.
Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.
Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____ _____
Physician Patient/Guardian

_____ _____
Effective from Date of Treatment: Date of Signature