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*General Orthopedics, Hand  
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John V. Hogikyan, M.D.  
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Adrienne Spirt, M.D.  
*General Orthopedics, Ankle  
and Foot Surgery*

Ypsilanti Office:  
Michigan Orthopedic Center  
5315 Elliott Drive  
Suite 202  
Ypsilanti, Michigan  
48197  
(734) 712-0600  
FAX (734) 712-0522

Saline Office:  
The Professional  
Office Building  
420 Russell  
Suite 109  
Saline, Michigan  
48176  
(734) 429-1540  
FAX (734) 429-1543

Brighton Office:  
Woodland Health Center  
7575 Grand River Avenue  
Suite 112  
Brighton, MI  
48114  
(810) 844-7557  
FAX (810) 844-7561

Dear Patient:

You have recently been referred to Community Orthopedic Surgery, P.C. for treatment. Your first appointment has been scheduled to see one of our physicians.

Enclosed is our **NEW PATIENT INFORMATION PACKET**. Inside you will find the following:

- A brochure explaining our practice and office policies.
- A map with the location of our offices on the reverse side of this brochure.
- New patient insurance information form(s) and financial policy of our office.
- A patient medical history form.
- Notice of privacy practices.

In order to assist us in your care, please complete, sign and date the enclosed forms and bring the completed forms with you to your first appointment. Please bring your insurance card(s) to your appointment as well.

If your insurance requires a referral, please contact your primary care physician prior to your appointment. Please bring a copy of the referral or have your primary care physician fax a referral to our office at (734) 712-0522.

If you have any questions regarding this information, please call our office at (734) 712-0600 and ask for the new patient representative. We look forward to caring for you and thank you for your cooperation.

**Community Orthopedic Surgery, P.C. & Huron Valley Hand Surgery**  
5315 Elliott Drive, Suite 202  
Ypsilanti, MI 48197

**Notice of Privacy Practices**

**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.**

Protected health information, about you, is maintained as a record of your contacts or visits for healthcare services with our practice. Specifically, “protected health information” is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Our practice is required to follow specific rules on maintaining the confidentiality of your protected health information, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law. If you have any questions about this Notice, please contact our Privacy Manager.

**Your Rights Under The Privacy Rule**

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Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

***You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices*** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

***You have the right to authorize other use and disclosure*** - This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

***You have the right to designate a personal representative*** – This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

***You have the right to inspect and copy your protected health information*** - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

***You have the right to request a restriction of your protected health information*** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

***You have the right to request an amendment to your protected health information*** - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

***You have the right to request disclosure accountability*** - This means that you may request a listing of disclosures that we have made, of your protected health information, to entities or persons outside of our office other than for the purposes of treatment, payment, healthcare operations, or a purpose authorized by you.

## **How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health care information that we are permitted to make.

**Treatment** - We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other healthcare providers who may be involved in your care and treatment. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.

**Payment** - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**Healthcare Operations** - We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating deidentified information.

## **Other Permitted and Required Uses and Disclosures**

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We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

**To Others Involved in Your Healthcare** - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**As Required By Law** - We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

**For Public Health** - We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

**For Communicable Diseases** - We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**For Health Oversight** - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

**In Cases of Abuse or Neglect** - We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.

**To The Food and Drug Administration** - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, to monitor product defects or problems, to report biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

**For Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**To Law Enforcement:** We may also disclose protected health information, as long as applicable legal requirements are met, for law enforcement purposes.

**To Coroners, Funeral Directors, and Organ Donation** - We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**In Cases of Criminal Activity** - Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**For Military Activity and National Security** - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service.

**For Workers' Compensation** - Your protected health information may be disclosed, by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**When an Inmate** - We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures** - Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

## **Complaints**

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You may address complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

Community Orthopedic Surgery, P.C.



& Huron Valley Hand Surgery

www.communityorthopedics.com

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Saline Office:  
The Professional  
Office Building  
420 Russell  
Suite 109  
Saline, Michigan  
48176  
(734) 429-1540  
FAX (734) 429-1543

Brighton Office:  
Woodland Health Center  
7575 Grand River Avenue  
Suite 112  
Brighton, MI  
48114  
(810) 844-7557  
FAX (810) 844-7561

## ACKNOWLEDGMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices from Community Orthopedic  
Surgery P.C. & Huron Valley Hand Surgery.

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)





*Accidents or Injuries cont.....*

Case Adjuster Fax#: \_\_\_\_\_

Name on Car Insurance

Policy: \_\_\_\_\_

Mail Claims to (address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Is there an attorney involved?  Yes  No

Attorney Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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**Is this a liability Case?**  Yes  No

Date of Injury: \_\_\_\_\_

Place of Injury: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Mail Claims to  
(address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Is there an attorney involved?  Yes  No

Attorney Name: \_\_\_\_\_ Phone # \_\_\_\_\_

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I attest that the information that I have provided on this form is complete and accurate to the best of my knowledge.

I hereby authorize Community Orthopedics Surgery, P.C. to furnish any medical information necessary to process my insurance claim (s) for my treatment acquired in the course of the examination or hospitalization.

I authorize payment of medical and/or surgical benefits to Community Orthopedic Surgery, P.C.

*By signing this form you acknowledge that you understand the provider's charge may exceed the insurance allowed amount and payment. You will be responsible for any balances, such as co-insurance, co-payments and deductibles. We accept: **VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH, OR CHECK.***

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature (parent or guardian if patient is under 18 years of age)

# COMMUNITY ORTHOPEDIC SURGERY, P.C. & HURON VALLEY HAND SURGERY

## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a *statement of our Financial Policy* that we require you read and sign prior to any treatment. ALL PATIENTS MUST complete our INFORMATION AND INSURANCE FORM before seeing the doctor.

### **PAYMENT IS DUE AT THE TIME OF SERVICE**

**WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS**

### **REGARDING INSURANCE PLANS WE DO NOT PARTICIPATE WITH:**

**We require that charges be paid in full at the time of service when the charges are \$200.00 or less.** We will provide you with an itemized receipt that you can turn in to your insurance company for reimbursement. For charges exceeding \$200.00, we will submit the charges to your insurance carrier on your behalf; however, you are responsible for the balance not paid by your insurance carrier.

Since we are not a party to the agreement with your insurance carrier, it is NOT OUR POLICY to contact carriers to establish why they have not paid or why they paid less than originally indicated. *Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your insurance carrier.*

Patients having an elective surgical procedure will be required to pay a **down-payment of 20% of the physician's surgery fee** before surgery will be scheduled.

### **USUAL AND CUSTOMARY RATES:**

**Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.**

**Adult Patients:** Adult patients are responsible for full payment at the time of service.

**Minor Patients:** The adults accompanying a minor and both parents (or guardians of the minor) are responsible for full payment. For **unaccompanied minors, non-emergency treatment may be denied if parental consent to treat the minor does not accompany the patient** along with pre-authorization for charges to an approved credit card, Visa, Mastercard, Discover or American Express, or payment by cash or check at the time of service has been verified.

### **REGARDING INSURANCE PLANS WE DO PARTICIPATE WITH:**

**We require that co-pays and charges for non-covered services be paid at the time of service.**

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

**Orthopedic History Sheet**

Today's Date: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Dominant Hand:**  Right  Left

What are you seeing the doctor for today? \_\_\_\_\_

If this is a re-visit to our office for a new problem, list any changes to your health, medicines, or allergies since previously seen. \_\_\_\_\_

Date of Injury/Onset: \_\_\_\_\_ On which side is the injury?  Right  Left

Please describe how your injury happened. \_\_\_\_\_

Have you been treated by anyone else for this problem?  Yes  No

If yes, by whom, when and where were you treated? \_\_\_\_\_

Did you have X-rays taken?  Yes  No Where? \_\_\_\_\_

Were you put on any medication for this problem?  Yes  No

If yes, what type of medication and are you taking it now? \_\_\_\_\_

What increases your pain or symptoms? \_\_\_\_\_

What decreases your pain or symptoms? \_\_\_\_\_

What is your current work status?  No Restriction  Working w/Restriction

Off Duty  Disabled  Unemployed  Homemaker  Retired

If you are not working, what was your last day at work? \_\_\_\_\_

**Family History** (*These questions apply to your mother, father, brother, sister, or child.*)

	Please Specify:	M	F	B	S	C
Family history of arthritis?						
Family history of bone disease?						

**Please list previous hospitalizations and/or surgeries:**

\_\_\_\_\_  
\_\_\_\_\_

If you have any questions about this form, or if there is other information which you have or which you feel might be important, please discuss it with the doctor. Also, if any of the information that you have provided should change, please inform the doctor. Thank you, Community Orthopedic Surgery

MEDICAL HISTORY	Yes	No	MEDICAL HISTORY	Yes	No	MEDICAL HISTORY	Yes	No
Chronic cough or lung problems			Chronic back problems			Circulation problems		
Shortness of breath at rest			Excess bleeding from surgery			Hard of hearing		
Shortness of breath w/exercise			History of anemia (low blood count)			Wear glasses/contact lenses		
Recent cold, bronchitis or pneumonia			Diabetes, since:			Problems walking		
History of asthma or wheezing			Liver disease/jaundice/hepatitis			Chemotherapy		
High blood pressure - how many yrs?			Kidney disorder			Immunizations up-to-date		
Heart attack - Date:			Stomach ulcer			History of motion sickness		
Heart failure - Date:			Chronic heartburn			Are you on a special diet		
Chest discomfort/tightness w/exercise			Hiatal hernia			Problems chewing/swallowing		
Irregular heartbeat - Date:			Transfusion - Date:			Depression/Psychiatric condition		
Mitral valve prolapse			Could you be pregnant			Substance abuse		
Heart murmur			Date last menstrual period:			Alcohol drinks per week:		
Stroke/TIA/weakness/paralysis			Dentures/bridges/caps			Years smoked:          packs/day		
Epilepsy/seizure - Date last seizure:			Skin problems			Date stopped smoking:		
Exam by cardiologist (heart doctor)			If yes, Dr's name/city:			Year:		
Heart catheterization			If yes, where			Year:		
Exercise stress test			If yes, where			Year:		
Ultrasound of heart (echocardiogram)			If yes, where			Year:		
Pacemaker			If yes, where			Year:		

ARE YOU ALLERGIC TO:	Yes	No	Reaction	Do you have or have you ever had any of the following:	
Latex				Arthritis	Y N
Any food				Blood clots	Y N
Adhesive tape				Cancer	Y N
Iodine on your skin				Injury with long-term impairment	Y N
Medication Allergies?			<i>If yes, list drug and reaction below.</i>	Joint pain	Y N
1)				Numb arm or leg	Y N
2)				Pulmonary embolism	Y N
3)				Rheumatoid arthritis	Y N
4)				Thyroid disease	Y N
5)				Keloids	Y N
				Lupus	Y N

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

Please **List All Prescription and Non-Prescription Medications** you are presently taking, including dosage and frequency. Include non-prescription medications, such as iron, aspirin, antacid, laxatives, eyedrops, vitamins and herbal supplements.

Medication - Dose - Times Per Day Taken	Medication - Dose - Times Per Day Taken	Medication - Dose - Times Per Day Taken
1)	6)	11)
2)	7)	12)
3)	8)	13)
4)	9)	14)
5)	10)	15)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Today's Date