4052 Legacy Parkway Suite 200.
Lansing, MI 48911
Phone: 517-272-9700
Fax: 517-272-9706
Visit us at www.glcor.com

Great Lakes Center of Rheumatology

Mark Braden DO

Osteopathic Manipulative Medicine Department

Date of Appointment:____

Arrival Time:____________________ Appointment Time:__________________ Provider: Dr. Mark Braden_

Welcome to Great Lakes Center of Rheumatology

Our rheumatology practice aims to care for patients in a compassionate and cutting-edge style. We believe in the treatment of the entire person and our goal is to work with everyone to find the treatment plan that works for them.

This appointment was requested by another physician who is treating you and who should have already notified you of this appointment. The following points should be kept in mind to avoid delays or the need to reschedule. Visits with our physicians are by appointment only.

- **Due to the length of this packet, please arrive 20 minutes prior to your scheduled appointment time. This allows us time to process your chart. Arriving less than 20 minutes prior to your appointment will result in having to reschedule your appointment.**
- Have your attached new patient information packet COMPLETED PRIOR TO YOUR APPOINTMENT! Due to the length and detail of this paperwork, not having this completed when you arrive, will require us to reschedule your appointment.
- Bring a picture ID and all of your current insurance cards, if you do not bring your insurance cards to your new patient appointment, your appointment will be rescheduled.
- Bring copies of lab and X-ray reports with you to your appointment, if applicable.
- If your insurance changes between scheduling the appointment and your appointment date, please call our office to make sure that we accept your new insurance.
- We are frequently asked to fill out paperwork. It is office policy to meet with a patient at least 3 times before we are comfortable filling out paperwork.
- **COPAYS ARE DUE AT THE TIME OF SERVICE!** For your convenience, we accept Visa, MasterCard, and Discover. If your insurance does not cover office calls, you will be required to pay at the time of service. If you are unsure of your copay amount, please contact your insurance carrier prior to your appointment.

Contact Information

Great Lakes Center of Rheumatology

Address: 4052 Legacy Pkwy Suite 200.
Lansing, MI 48911

Phone: 517-272-9700

Fax: 517-272-9706

Website: GLCOR.com

OMM Office Hours: 7:00AM – 4:00PM Wednesday, Thursday, Friday. Closed for lunch daily 12:00PM – 1:00PM

Directions to Great Lakes Center of Rheumatology

From Ann Arbor: Take 23 North to 96 West (exit #60B on LEFT toward BRIGHTON/LANSING) to 496 towards Lansing (exit 106B). Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Detroit: Take 96 West to 496 towards Lansing (exit 106B). Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Flint: Take 69 West to 127 South (exit #89A towards LANSING/ JACKSON). Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Grand Rapids: Take 96 East to 496W/ US-127 N via exit 106B toward E Lansing. Take the Jolly Road exit (#11). See below for instructions once you exit the freeway.

From Kalamazoo: Take 94 East to 69 North (exit #108 toward LANSING). Merge onto 96 East via exit #72 toward DETROIT. Then merge onto 496 W/US 127 North (exit #106B) toward E Lansing to the Jolly Road Exit (#11). See below for instructions once you exit the freeway.

From St Johns: Take 27 South to 127 South. Take Jolly Road exit (#11). See below for instructions once you exit the freeway.

*** At the end of the exit ramp there will be a stop light. Turn RIGHT at the stop light. This is Dunckel Road. Follow this road around the curve. You will see a Quality Dairy on the corner of Jolly and Dunckel. Go through the light to the street which is Legacy. Turn left on Legacy (this is the only way you can turn). We are the second to last building on the left (brick building). If you hit pine tree you went too far. ***

GLCOR
OMM Department
New Patient Packet

PATIENT REGISTRATION FORM

Date: ________________ Work Related? Y / N Auto Related? Y / N If yes, injury date _______________

PERSONAL INFORMATION

Name: _________________________________ Date of Birth: ________________ Social Security#________________

Address: _________________________________ City: _____________________ State: ______ Zip: ________________

Primary Phone: __________________ Alternate Phone: _____________________Email address: ___________________

Race:_____________________________Ethnicity:_________________________Language:________________________

RESPONSIBLE PARTY INFORMATION

Primary Insurance Company: _____________________________ Subscriber Name: ___________________________

Contract/ Policy #: __________________________________ Group #: ___________________ Co-pay: _____________

Subscriber relationship to patient: Self / Spouse / Parent Gender: M / F

Subscribers Date of Birth: __________________

Secondary Insurance Company: ___________________________ Subscriber Name: ____________________________

Contract/ Policy #: ______________________________ Group #: _____________________ Co-pay: ________________

Subscriber relationship to patient: Self / Spouse / Parent Gender: M / F

Subscriber Date of Birth: __________________

*** For Third Insurances- Please write in policy/ Subscriber information in the back of this form***

EMERGENCY CONTACT INFORMATION

Name: _____________________________Phone: ______________________Relationship to Patient: ________________

REFERRAL INFORMATION

Primary Care Physician: _______________________ Phone: _______________

PATIENT INFORMATION RELEASE

Patient Name: ________________________ DOB: _____________________

I hereby give permission to release medical information regarding myself to the family and friends listed below:

____
____
____

Signature of Patient: _________________________ Date: __________________________________

The following information will assist us in your care, and in any communications with you, while protecting your confidentiality. Please circle "YES" or "NO" and fill in the necessary information.

I give permission to:

YES NO N/A Leave a message with test results on voicemail at my Primary Phone #.

YES NO N/A Leave a message at my Primary Phone # requesting I call the office back.

YES NO N/A Leave a message at my Alternative Phone # requesting I call the office back.

YES NO N/A Fax lab results, x-ray results, or any other information regarding my condition, to my primary care physician, or the physician that Great Lakes Center of Rheumatology is referring me to.

YES NO Fax or telephone information to and from my insurance company. This may be required, in some cases, to get the claim paid or obtain a prior authorization for medication.

YES NO Send me a notice of a potential Research Study that I may qualify for.

Signature of Patient: ________________________________ Date: _________________

CONSENT FOR TREATMENT:
I voluntarily consent to treatment by the medical staff of Great Lakes Center of Rheumatology as deemed necessary in their judgment. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments or tests.

Patient or Responsible Party Signature: ____ Date: _______________

HIPAA PRIVACY PRACTICES:
I agree to Great Lakes Center of Rheumatology's HIPAA and Privacy Practices. If you would like a copy of all policies, please request one at the front desk

Patient or Responsible Party Signature: ____ Date: _______________

RELEASE OF INFORMATION:
I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Great Lakes Center of Rheumatology. I am aware that my provider may release my medical information to other providers, in order to continue my care.

Patient or Responsible Party Signature: ____ Date: ______________

PAYMENT POLICY:
Medicare Patients: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patient will be billed the balance.

HMO, PPO, or other Managed Care Patients: You will be responsible for paying your annual deductible and co-payments, as well as any changes for non-covered services. All copayments are due at the time of service.

Commercial Insurance Patients: If you are covered but a private or commercial plan in which our physicians are not providers, we will bill your insurance company as a courtesy, however, if your plan does not pay, you will be responsible for the entire charge. If your insurance plan does not cover office calls, you will be responsible to pay the entire amount at the time of service.

Patient co-pays are due at the time of check-in. If you do not pay your co-pay at check in you will receive a paper statement in the mail, that amount is due when received. If your payment is not received within 30 days, you will incur a $20 late fee. If your payment is not received within 60 days, you will incur a second $20 late fee. After 90 days of no payment you will be sent to collections and unable to be seen or scheduled with the practice. At any time, you may set up a payment plan with the office. There will be a $5 fee for any phoned in prescription refills. It is patient responsibility to take care of all refills during appointment. Patients may schedule an appointment to receive their refills. All cancellations require 24-hour notice, the fee for not cancelling is $25.

Patient or Responsible Party Signature: ____ Date: ______________

MEDICARE PATIENTS ONLY:
This office is required to keep your signature on file authorizing us to file claims to Medicare for you and that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to the party who accepts assignments or to me. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card: ____ Date: __________________

If you have a supplement policy and it is a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file.
I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card: ____ Date: ____________________

GLCOR
OMM Department
New Patient Packet

Chief Complaint: ____

____

____

History of Chief Complaint:
Do you have pain? [ ] Yes [ ] No
Have you had previous episodes of this pain? [ ] Yes [ ] No
When did this episode of pain or problem begin?_____________________________________

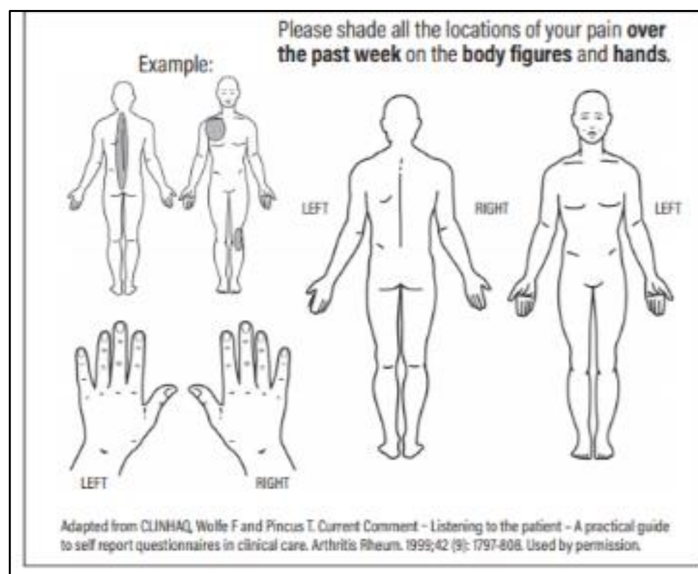
Overall, your pain is (circle one)

Improving About the same Worsening

Throughout the day, your pain: (circle one)

Increases Decreases Stays the same

How did the current episode of pain occur? (mark all that apply)
[ ] Twisting [ ] Vehicle Accident [ ] A Fall
[ ] Pushing/Pulling [ ] Recreational [ ] Overuse
[ ] Bending [ ] Work Related [ ] Degenerative
[ ] Lifting [ ] Unknown [ ] Other



If your pain is the result of an injury, please list date of incident and describe incident:
Date of injury:_____________
Description:_____________________________________
____
____

Type of pain:
[ ] Sharp [ ] Dull [ ] Throbbing [ ] Aching [ ] Periodic [ ] Intermittent [ ] Occasional [ ] Constant

Does your pain interfere with sleep? If so when?
[ ] Lying still [ ] Changing positions [ ] Both

List specific activities which relieve your pain:
[ ] Sitting [ ] Walking [ ] Wearing splints/orthotics [ ] Exercise [ ] Heat [ ] Cold [ ] Rest [ ] Standing
[ ] Stretching [ ] Medication [ ] Massage [ ] Nothing

List specific activities which increase your pain:
[ ] Sitting [ ] Walking [ ] Reaching overhead [ ] Reaching across [ ] Yawning [ ] Household activities
[ ] Sleeping [ ] Bending/Standing [ ] Walking up/down stairs [ ] Reaching forward [ ] Talking
[ ] Sports [ ] Coughing [ ] Laying Down [ ] Reaching Back [ ] Chewing [ ] Repetitive Activity
[ ] Squatting [ ] Other:____

How do you define treatment success?
[ ] Freedom from all pain [ ] Any amount of pain relief [ ] Doing all desired activities
[ ] Tolerating simple activities

Diagnostic Tests/ Prior Treatment

Please list prior diagnostic treatments that have been performed for this **specific** problem.
TEST BODY AREA/Approx. Date

X-Rays____
CT (Cat) Scan___________________________________
Myelogram______________________________________
MRI Scan_______________________________________
Discogram______________________________________
Bone Scan______________________________________
EMG/Nerve Conduction_____________________________
Other____

Please list practitioners you have seen for this problem along with the approximate dates:
____
____
____

Past Surgical History
Please list any past major surgeries or dental procedures you've had with the approximate dates:
____
____
____

List any previous injuries you've had and when. (motor vehicle accidents, bad falls, sports related injuries, etc)
____
____
____

Past Medical History:

Please list all medications and supplements that you take now. Include dosage and frequency:
____
____
____
____

Allergies:
____
____

Chronic medical problems that you are being treated for:

____
____
____

Type of Treatment	Improved	Made Problem Worse	No Change
Stretching Exercises	______	______	______
Ultrasound	______	______	______
Heat/Ice	______	______	______
Massage	______	______	______
Electrical Stimulation	______	______	______
Physical Therapy	______	______	______
Home Exercises	______	______	______
Traction	______	______	______
Bed Rest	______	______	______
Chiropractic Treatment	______	______	______
Osteopathic Treatment	______	______	______
Injection Therapy	______	______	______
Brace	______	______	______
Acupuncture	______	______	______
Anti-Inflammatory Medication	______	______	______
Narcotic Medication	______	______	______
Muscle Relaxant Medication	______	______	______
Anti-Depressant Medication	______	______	______
Surgery	______	______	______

Social History

Did you or do you currently smoke? If so for how long?_______________
Have you used smokeless/chew tobacco? How long?________________
Have you used e-cigarettes/vape pens? How long?_________________

Relationship status:____
Do you have children? If yes, please list ages____
*Is there a religious/spiritual preference that may affect your care?______________________________
*In your opinion, have you experienced physical, sexual, verbal or mental/emotional abuse?________________
(*optional questions)

What is your work status?____
Occupation?____
Do you have work restrictions?____

Do you use or have you used IV drugs? [ ] yes [ ] no
Do you drink alcohol? [ ] yes [ ] no If yes, how much?___________________________________
If previous drinker, when did you quit?____
Do you drink caffeine? [ ] yes [ ] no If yes, how much?___________________________________
Do you drink alcohol to control pain? [ ] yes [ ] no

Do you use marijuana? [ ] yes [ ] no If yes, how often?__________________________________
How often do you exercise or perform physical activity enough to raise your heart rate?
[ ] None [ ] 30 minutes a few days/week [ ]1-2 hours/week [ ] 2-4 hours/week
[ ] More than 4 hours/ week