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Visit Us At:
www.glcor.com

Great Lakes Center of Rheumatology

Mark Braden, DO

Osteopathic Manipulative Medicine and Platelet Rich Plasma Injections

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 style treatment 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.

If you must **CANCEL/ RESCHEDULE** an appointment, **we require a minimum of 24 HOURS** notice for all NEW PATIENT APPOINTMENTS. Failure to cancel your scheduled appointment will result in a **$50 charge.**

- **Due to the length of this packet, please arrive 20 MINUTES prior to your appointment time with this packet completed in FULL. This allows us time to process your chart. Arriving less than 20 MINUTES prior to your appointment or not having this packet completed will result in having to reschedule your appointment.**
- Bring your 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 our 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 Cash, Check, Visa, MasterCard, and Discover. If your insurance does not cover office visits, you will be required to pay at the time of service. If you are unsure of your co-pay amount for a specialist, please contact your insurance carrier prior to your appointment.

Your New Patient Appointment is scheduled for:

Date:_____ **Arrival Time:** _____

Appointment Time: _____ **Provider:** _____

Great Lakes Center of Rheumatology
Patient Information Release

Patient Name:_____ DOB: _____

I hereby give permission to release any medical information regarding myself to the family, friends and/or physicians listed below:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Patient Signature: _____ Date: _____

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

I give Great Lakes Center of Rheumatology permission to:

YES NO N/A | Leave a voicemail on my Primary Number.
YES NO N/A | Leave a voicemail on my Alternative Number.
YES NO | Send me a notice of potential Research Study that I may qualify for.
Please Note: This would result into a transfer of care if you qualify for any Research Studies.

Patient Signature: _____ 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/ Responsible Party Signature: _____ Date: _____

Great Lakes Center of Rheumatology

Privacy Practice Part 1

HIPAA Privacy Practice:

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

Patient 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 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/supplement carriers. However in the event of 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 of non-covered services. All co-payments are due at the time of service.

Commercial Insurance Patients: If you are covered by 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 visits, you will be responsible to pay the entire amount of 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 the patient's responsibility to take care of all refills during the appointment.** Patients may schedule an appointment to receive their refills. All cancellations require **24 hour notice**; the fee for not canceling is $25.

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Great Lakes Center of Rheumatology

Privacy Practice Part 2

Medicare Patients Only:

The 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 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 the authorization to be used in place of the original and request payment of medical insurance benefits either to the party who except assignments or to me. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature: _____ Date: _____ ☐ Not Applicable

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 authorize 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.

Patient Signature: _____ Date: _____ ☐ Not Applicable

Patient Name: _____ Date of Birth: _____

**** If you do not have Medicare, Please check "Not Applicable", Print and Sign your name, and complete DOB and Date ****

Great Lakes Center of Rheumatology
Patient Registration Form

Work Related? Yes / No Auto Related? Yes / No Date: _____

Personal Information:

Name: _____ Date of Birth:_____ Sex:_____

Address: _____ City: _____ State: ____ Zip:_____

Primary Number:_____ Alternative Phone: _____

Email Address: _____

Race:_____ Ethnicity: _____ Language: _____

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Responsible Party Information:

Primary Insurance Company: _____ Policy Number:_____

Group Number: _____ Specialist Co-Pay: _____

Subscriber Name: _____ Subscriber DOB: _____ Gender: _____

Subscribers Relationship (if not self): _____

Secondary Insurance Company: _____ Policy Number:_____

Group Number: _____ Specialist Co-Pay: _____

Subscriber Name: _____ Subscriber DOB: _____ Gender: _____

Subscribers Relationship (if not self): _____

Emergency Contact Information:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Referral Information:

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Great Lakes Center of Rheumatology

Directions to Great Lakes Center of Rheumatology

Address: 4052 Legacy Parkway, Lansing MI 48911

Phone: 517-272-9700 **Fax:** 517-272-9706

Ann Arbor, MI:

Take **23 North to 96 West** to **Exit 60B**, on the **Left** towards **Brighton/ Lansing** to **496** towards **Lansing**, take **Exit 106B**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

Detroit, MI:

Take **96 West** to **496 towards Lansing,** Take exit **106B**. Take **Exit 11** to **Jolly Road.** **

** see below for further instructions **

Flint, MI:

Take **69 West to 127 South**, Take **Exit 89A** towards **Lansing/ Jackson**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

Grand Rapids, MI:

Take **96 East** to **496W/ US-127 North**, Take **Exit 106B** toward **East Lansing**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

Kalamazoo, MI:

Take **94 East** to **69 North**, Take **Exit 108 towards Lansing**. **Merge** onto **96 East**, Take **Exit 72 towards Detroit**. Merge onto **496 W/US 127 North**, Take **Exit 106B** towards **East Lansing** to **Exit #11** to **Jolly Road**

** see below for further instructions **

St. Johns, MI:

Take **27 South** to **127 South**. Take **Exit 11** to **Jolly Road.**

** see below for further instructions **

*** At the end of the exit ramp there will be a stop light. Turn **Right** at the stop light. You will be on **Dunckel Road**. Follow this road around the curve, you will see a **Quality Dairy** on the **corner of Jolly and Dunckel**. Go **thru 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. ***

Osteopathic Manipulation Medicine
Patient History Form

Date of first appt: _____

Describe briefly your present symptoms:

_____

_____

Date symptoms began *(approximate)*:_____

How long have you had the current pain:_____

Previous treatment for this problem *(include physical therapy, surgery and injections; medications to be listed later)*:

_____

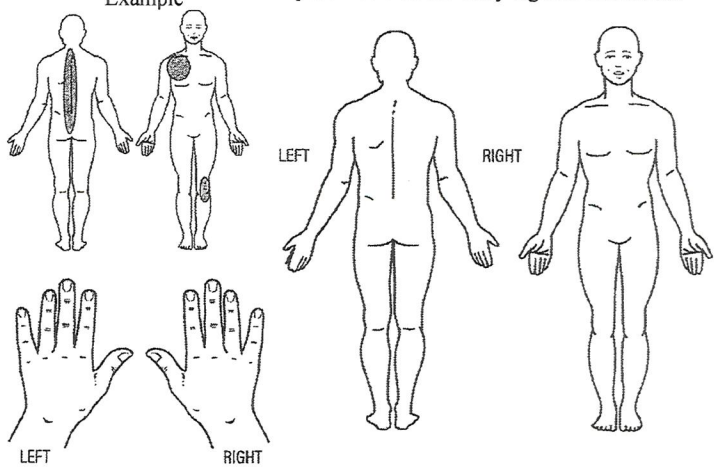
_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

Please shade all the locations of **your pain over the past week** on the body figures and hands.



Adapted from CLINHAQ Wolfe Fand Pincus T. Current Comment — Listening to the patient — A practical guide to self report questionnaires in clinical care.Arthritis Rheum. 1999;42 (9): 1797-808. Used by permission.

OVERALL, your pain is? *(Check one)*

[ ] Improving [ ] About the same [ ] Worsening

Throughout the day, your pain: *(check one)*

[ ] Increases [ ] About the same [ ] Decreases

How did your current pain start?

(check all that apply)

[ ] Twisting [ ] Pushing [ ] Pulling

[ ] Bending [ ] Lifting [ ] A Fall

[ ] Overuse [ ] Recreational [ ] Degenerative

[ ] Work Related [ ] Motor Vehicle Accident

[ ] Unknown [ ] Other: _____

If your pain is the result of injury

Date of injury:_____

How did the injury occur:_____

_____

_____

Type of pain: *(Check all that apply)*

[ ] Sharp [ ] Dull [ ] Throbbing [ ] Aching

[ ] Periodic [ ] Intermittent [ ] Occasional [ ] Constant

Does your pain interfere with sleep? If so when?

[ ] Lying still [ ] Changing positions [ ] Both

Check activities that relieve your pain:

[ ] Sitting [ ] Walking [ ] Stretching [ ] Massage [ ] Exercise

[ ] Standing [ ] Medication [ ] Rest [ ] Heat [ ] Cold compress

[ ] Wearing splints/ Orthotics [ ] Nothing

Patient Name: _____ Date of birth: _____

Osteopathic Manipulation Medicine
Patient History Form

Check the activities that increase your pain:

(Check all the apply)

[ ] Sitting [ ] Walking [ ] Sleeping [ ] Yawning

[ ] Chewing [ ] Coughing [ ] Talking [ ] Bending

[ ] Standing [ ] Squatting [ ] Sports [ ] Reaching overhead

[ ] Reaching across [ ] Reaching forward [ ] Reaching back

[ ] Walking up stairs [ ] Walking down stairs [ ] Laying down

[ ] Household actives [ ] Repetitive Activity

[ ] Other: _____

What would you like to achieve from OMM?

(Check all that apply)

[ ] Free from all pain [ ] Any amount of pain relief

[ ] Doing all desired [ ] Tolerate simple

activates activates

Comment: _____

_____

_____

_____

List any other chronic medical problems you are being treated for:

1. _____ 2. _____

3. _____ 4. _____

6. _____ 6. _____

Social History

Do you drink caffeinated beverages? [ ] Yes [ ] No

If yes, how many cups/ glasses per day and type of beverage?

_____

Do you drink alcohol? [ ] Yes [ ] No

If yes, how many cups/ glasses per day and type of beverage?

_____

Has anyone ever told you to cut down on your drinking? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No [ ] Past *(tobacco or vape)*

If yes, how much and how long?_____

Previous smoker, how long? _____

Do you use smokeless/ chewing tobacco? [ ] Yes [ ] No

Do you use marijuana? [ ] Yes [ ] No

Do you exercise regularly? [ ] Yes [ ] No

Type: _____

Amount per week: _____

How many hours of sleep do you get at night:

_____

Do you feel like you're getting enough sleep at night? [ ] Yes [ ] No

Do you wake up feeling well rested? [ ] Yes [ ] No

Occupation: _____

Do you have work restrictions? _____

Allergies: _____

_____

_____

Patient Name: _____ Date of birth: _____

Osteopathic Manipulation Medicine

For Woman Only

Are your periods regular? [ ] Yes [ ] No

How many days apart: _____

Date of last pap: _____

Number of children: _____

Age when period began: _____

Date of last period: _____

Bleeding with menopause: [ ] Yes [ ] No

Number of miscarriages: _____

Present Medications

List any medications you are **CURRENTLY** taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Previous Medications

In the **PAST**, have you tried any of the following? If yes, Please indicate the medications name and how long you were on the medication?

Anti-Inflammatory Medications		Narcotic Medications	
Anti-Depressant Medications		Muscle Relaxant Medications	

Patient Name: _____ Date of birth: _____

Osteopathic Manipulation Medicine

Previous Medical History

In the **PAST**, has any of this treatment's Improved, Made the problem worse or gave no change?

Treatment	Improved	Made Problem Worse	No Change
Stretching Exercises			
Heat/ Ice			
Massage			
Electrical Stimulation			
Physical Therapy			
Home Exercises			
Traction			
Bed Rest			
Chiropractic Treatment			
Osteopathic Treatment			
Injection Therapy			
Brace			
Acupuncture			
Surgery			

In the **PAST**, have you had any diagnostic testing for the problem you are being seen for today? If so, when and where.

Ultrasound		Bone Scan	
X-ray		EMG/ Nerve Conduction	
CT Scan		MRI Scan	
Myelogram		Discogram	

Previous Surgeries

Type	Year	Reason

Patient Name: _____ Date of birth: _____