Safa Kassab, MD
Maher Bahu, MD
Robert Howard, DO
Nicholas Schroder, MD
Joseph Ward, MD

First Name		Last Name		MI
DOB	Phone Number		Email	

Address

Primary Care: Name, Address & Phone	Pharmacy: Name & Address
Cardiologist: (if applicable) Name, Address, Phone	Who referred you?
	Is your injury due to a Work Accident?
Marital Status	Is Your Injury Due to an Auto Accident?

Race	Ethnicity	Gender	If Yes, what is the date of accident?
Emergency Contact & Number			Preferred Pharmacy

Height	Weight
Do You Smoke?	
If Yes:	# of Years
Do You Drink Alcohol?	
If Yes	

Please List Any Medications:

Name	Dose

44038 Woodward Ave,
Bloomfield Hills, MI, 48302

www.OSOC.com
248.335.2977

7650 Dixie Highway,
Clarkston, MI, 48346

Please list any prior surgeries:

Please list any known Drug Allergies.

Do you/have you experienced any of the following? (Please Check)

	Rheumatic Fever		Epilepsy
	Jaundince		Heart Attack
	Inflammatory Rheumatism		Stroke
	Hepatitis		Stomach Ulcer
	Diabetes		Asthma / Hay Fever
	High Blood Pressure		Hives/Skin Rash
	Anemia		Kidney Problems
	Arthritis		Other (please specify)

Please List Any Important Family History:

1) **I hereby authorize Orthopedic Specialist of Oakland County (OSOC), to release any information required in the course of my treatment to my insurance company or another physician. This information may be sent by U.S. Mail or fax machine.**
2) **I hereby authorize payment Directly to OSOC for all services rendered**
3) **I understand that if our practice is not a participating provider for my insurance, that I am responsible for the remaining amount unpaid by my insurance**

Signature: ____ Date: ________________

Orthopedic Specialists of Oakland County
Acknowledgement Form

This document is an abbreviated 'Notice of Privacy Practices.' It explains how health information about you may be used, and your rights, regarding the use of that information. Please review it carefully.
A full copy of the practice's 'Notice of Privacy Practices' will be made available to you upon request.

You have the right to:

- Ask to see, read, and/or obtain a copy of your health record
- Ask to correct information that you believe is wrong in your health record
- Ask that your health information not be used for certain purposes, for example, research
- Ask that copies of your health record be sent to whomever you wish (Please list below)
- Specify where and how you should be contacted
- Receive a paper copy of the full 'Notice of Privacy Practices'

Who is authorized to see confidential Patient Health Information (PHI)?

The 'Notice of Privacy Practices' describes the ways in which your PHI may be used without obtaining the patient's specific authorization. Certain uses such as for Treatment, Payment and health care operations are permitted.

1. Treatment of the patient, such as consultation between treating providers
2. Payment of health care bills (insurance claim submissions, authorizations and payment posting)

Written Authorizations:

To use or disclose PHI for almost any other reason, you will need to sign a written authorization prior to access or disclosure. Refer to the 'Notice of Privacy Practices' for a list of covered exceptions to the authorization requirement.

Exceptions to the Rules:

Under HIPAA, there are certain exceptions to these general rules. These exceptions are described in the 'Notice of Privacy Practices'. Disclosures can be made without patient authorization: subject to professional judgment, for public health and safety purposes, for government functions, law enforcement, and based on a judicial subpoena.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- By signing below, I acknowledge that I have read and understand this office's 'Notice of Privacy Practices.'
- I understand and acknowledge that I may receive appointment reminder calls/texts/emails, practice newsletters and continuing care cards, and I agree to receive these.

_______________________________	_______________________________
Print Name	Sign Name

____
Date

List any names and their relationship to you that you authorize us to release your health information to:

Patient Centered Medical Home (PCMH)

Dear Patient and Family,

Welcome to our practice. At our office, we continue to receive recognition as an office that provides care according to the standards of a Patient Centered Medical home (PCMH). A PCHM office provides comprehensive, coordinated health care to patients at all stages of their life. It is a health care partnership developed between the patient and his/her personal physician that may seem different to you.

As a valued patient, we are excited to discuss this rewarding approach to health care right here in our office with no additional cost or inconvenience to you. In fact, we think you will be very pleased with some of the patient friendly features that will be available to you now and in the future. Please take a moment to review the Patient-Provider Partnership Brochure. If you have not been provided with one, please ask our front desk. It describes each of our roles in caring for you. This is an important feature of our office.

As partners in your health care we look forward to discussing this information with you and answering any questions you may have.

Sincerely,

OSOC Team
Matt Bahu, MD
Robert Howard, DO
Safa Kassab MD
Nicholas Schoreder MD
Joseph Ward, MD

I have received information about the Patient Centered Medical Home.

______________________________________ ______________________________________
Print Name Sign Name

____
Date