Compass Sports Medicine & Orthopaedic Surgery
Julie Dodds, MD Susan Ott, DO Amy Worthing, PA-C, ATC
2900 Hannah Boulevard, Suite 212, East Lansing, MI 48823
(517) 319-1831 Fax: (517) 664-2930

Please Read Carefully ~~~~~ Important Appointment Information

Dear _____,

Welcome to *Compass Sports Medicine & Orthopaedic Surgery.*

You have an appointment scheduled on _____ at _____. Please arrive in our office at _____ for processing your paperwork and obtaining possible x-rays prior to seeing the physician. Please plan on being in our office approximately 2 hours.

On the day of your appointment, please bring the following with you:

- The enclosed New Patient forms. Please complete these forms in black or blue ink ***prior*** to your arrival.
- Your insurance card(s) and a picture ID
- X-ray and/or MRI CD/films that have been taken recently or within the last year. We do not need printed pictures.
- If your X-ray or MRI was done at MMP Imaging, MSU, Sparrow Hospital, or McLaren Hospital you DO NOT need to obtain these, we can view these here at our office. If they were done elsewhere, you DO need to obtain a copy from the facility where they were done and bring them to your appointment.
- You are scheduled to see a Specialist in Orthopaedic Surgery and/or Sports Medicine; therefore you may be required to have an additional X-ray.
- We have X-ray equipment in our office.
- If you do not bring your X-ray CD/film with you, we may require that you have X-rays done here in our office prior to seeing the physician and/or physician assistant, or you may be asked to reschedule your appointment.
- Operative Report from any previous surgery relating to the injury or problem area. You can obtain this from the surgeon's office and/or the facility where the surgery was performed.
- If you are being seen for a knee problem, please bring or wear shorts.
- If you are female and being seen for a shoulder problem, please bring or wear a tank top or sports bra.
- We do charge $10 for completion of forms, such as FMLA, disability
- We do charge for No Show / Missed Appointments
- We do not fill prescriptions in the evenings or weekends
- Workers Compensation and Auto patients must have all claim information prior to your appointment or it will not be scheduled or it will be canceled.

We are located in the Sparrow Health Science Pavilion (Michigan Athletic Club Facility) at:
2900 Hannah Boulevard, Suite 212, East Lansing, MI 48823

Please contact us at **517-319-1831** if we can assist you in anyway before your visit.
Our regular office hours are Monday through Thursday 8 am to 12 pm and 1 pm to 5 pm, and Friday 8 am to 12 pm and 1 pm to 2 pm.

We look forward to meeting you,
Dr. Julie Dodds, Dr. Susan Ott, Amy Worthing, PA-C, ATC, & Staff

Compass Sports Medicine & Orthopaedic Surgery

PERSONAL INFORMATION

Name:_____ Date of Birth:_____ Social Security #:_____-____-_____

Address:_____ City / State / Zip:_____

Ethnicity: Hispanic / Non-Hispanic / Other_____ Sex: **M / F** Marital Status: S / M / D / W

Race: American Indian / Asian / African American / Native Hawaiian / White / Other_____

Cell (if different than home): (____)_____ -_____ Home Phone: (____)_____ -_____

E-Mail Address: _____

Employer:_____ Address:_____

Work Phone: (____)_____ -_____ City / State / Zip:_____

Spouse Name:_____ Spouse DOB:_____ Spouse SS#:_____

Spouse Employer:_____ Spouse Work #:(____)_____ -_____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

BCBS/ Medicare/ PHP/ BCN/ Other: _____

Effective Date:_____ Co-Pay:_____

Policy/ID #:_____ Group#: _____

Policy Holder:_____

Relationship to Patient:_____

Date of Birth:_____

SECONDARY INSURANCE INFORMATION

BCBS/ Medicare/ PHP/ BCN/ Other: _____

Effective Date:_____ Co-Pay:_____

Policy/ID #:_____ Group#: _____

Policy Holder:_____

Relationship to Patient:_____

Date of Birth:_____

WORK COMP/AUTO INSURANCE INFORMATION

Date of Injury: _____ Claim #: _____

WC/Auto Company: _____ Address: _____

Caseworker Name: _____ Contact Phone: (____)_____ -_____ Fax: (____)_____ -_____

WC Employer: _____ Auto: Do you have medical insurance that is primary to your auto? YES/NO

EMERGENCY CONTACT

Name:_____ Relationship to Patient:_____ DOB: _____

Address:_____ City / State / Zip:_____

Home Phone: (____)_____ -_____ Work Phone: (____)_____ -_____ Cell: (____)_____ -_____

PHYSICIAN INFORMATION

Family Physician:_____ Phone:(____)_____ -_____

Referring Physician:_____ Phone:(____)_____ -_____

I authorize the release of any medical information necessary to process my insurance claim. I authorize payment of medical benefits to Compass Health for services rendered when they request that payment be made directly to them.

Signature:_____ **Date:**_____

I understand that I am ultimately responsible for payment of services that are rendered to me. I understand that Compass Health will bill my insurance company, but that I am responsible for any balance that my insurance does not pay as well as any copayments and/or deductibles.

Signature:_____ **Date:**_____

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Medical Information Release Form

Date: _____

Patient Name: _____

Date of Birth: _____

Purpose of Request - I authorize the practice to disclose or provide my protected health information to the following individual(s) who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1. Name:_____ Relationship:_____

2. Name:_____ Relationship:_____

3. Name:_____ Relationship:_____

4. Name:_____ Relationship:_____

Description of Information to be Disclosed - I authorize **Compass Health** to disclose all of my protected health information to my designated personal representative.

Expirations or Termination of Authorization – This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to Revoke or Terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Compass Sports Medicine & Orthopaedic Surgery
2900 Hannah Boulevard, Suite 212
East Lansing, MI 48823

Redisclosure – We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of McLaren Greater Lansing.

The following information will assist us in your care, and in any communications with you, while protecting your confidentiality. Please circle "yes" or "no".

I authorize messages to be left at the following:

Yes No Home Number
Yes No Cell Number
Yes No Work Number

I acknowledge that Compass Sports Medicine and Orthopaedic Surgery may send my health care information to another health care provider for the continuation of my care.

Signature of Patient or Guardian: _____

Compass Sports Medicine and Orthopaedic Surgery

Name:_____ Date of Birth:_____

Age: _____ Weight: _____ Height: _____

Primary Care Doctor: _____ Date of Last Physical Exam: _____

CHIEF COMPLAINT

Body Location: ☐ Knee ☐ Shoulder ☐ Other: _____ ☐ Right ☐ Left ☐ Bilateral
Describe your injury/problem, **how** and **when** it started: _____

_____

_____

Is this problem the result of a work accident/injury? NO ☐ YES ☐ auto accident? NO ☐ YES ☐
Is your injury sports related? NO ☐ YES ☐
Have you received prior treatment for this injury? NO ☐ YES ☐
When/Where?_____
Were you seen in an Emergency Room for this injury? Sparrow ☐ McLaren ☐ Other: _____

For this injury:

XRAY	NO ☐ YES ☐	Hospital/Facility: _____	Date: _____
MRI	NO ☐ YES ☐	Hospital/Facility: _____	Date: _____
Injections	NO ☐ YES ☐		
Physical Therapy	NO ☐ YES ☐	How long? _____	
Occupational Therapy	NO ☐ YES ☐	How long? _____	
Alternative Therapies	NO ☐ YES ☐	List: _____	
Medications	NO ☐ YES ☐	List: _____	

FAMILY HEALTH HISTORY

Family Member	Living	Deceased	Age/ Age at Death	Medical Problems/Cause of death
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

SOCIAL HISTORY

Occupation_____ Employer: _____
Hobbies/Sports_____
Student: NO ☐ YES ☐ School: _____ Grade Level: _____

Do you smoke? NO ☐ YES ☐ ___ Packs/Day for _____ Yrs/Months
Previously ☐ Quit ___ years ago at that time: ___ Packs/Day for _____ Yrs/Months
Drink alcohol? NO ☐ YES ☐ How much and how often_____
Do you use Recreational Drugs? NO ☐ YES ☐ Drug: _____ Frequency: _____
Do you live alone? NO ☐ YES ☐
Do you have an Advanced Directive? NO ☐ YES ☐

Name: _____

PAST MEDICAL HISTORY

Please circle all medical problems that you have had in the past.*

System Review		Other: Please Explain
CONSTITUTIONAL	Fevers Night sweats	
EYE	Visual loss or change Trauma Cataract Glaucoma	
EAR, NOSE, THROAT	Deafness Sleep Apnea Sinus Trouble	
RESPIRATORY	Shortness of breath Asthma Emphysema Bronchitis	
CARDIOVASCULAR	Heart attack Irregular Heartbeat Murmur Chest Pain Pacemaker High Blood Pressure Heart Stents	
CARDIOLOGIST NAME		**(If you have ♥ Stents or Pacemaker Please Provide Card to Nurse)**
GASTROINTESTINAL	Ulcers Crohns disease Hernia Ulcerative Colitis Heartburn Gall Bladder disease	
GENTITOURINARY	Prostate disease Difficulty Urinating Blood in urine Kidney disease	
HEMATOLOGIC	Blood clots Anemia Hepatitis Bleeding Problems	
METABOLIC	Diabetes Tremors Growth Changes Thyroid Disease	
NEUROLOGIC	Seizures Stroke Migraines Balance Changes Parkinsons Disease Head Injury Concussion	
MUSCULOSKELETAL	Fractures Sprains Dislocations Arthritis Osteoporosis Weakness	
PSYCHOLOGICAL	Eating disorders Substance abuse Depression Anxiety Bipolar	
SKIN	Infections MRSA VRE Open Sores Cellulitis	
IMMUNOLOGIC/ALLERGIC	Dermatitis Latex Allergy Iodine	
OTHER HEALTH PROBLEMS	Cancers Infectious Disease HIV	

Year	All Previous Surgeries/Hospitalizations	Complications

Name: _____

Have you or a family member had problems with anesthesia? NO ☐ YES ☐
Describe _____

MEDICATION ALLERGIES

Have you had an allergic reaction or side effect to any drugs or medications? NO ☐ YES ☐
List side effects and drugs _____
_____
_____

Preferred Pharmacy: _____ Location: _____

LIST CURRENT MEDICATIONS

Name of Medication	Dose	How often

The U.S. Congress passed a law that requires us to obtain the following information to receive payment for services to you.

1. Have you received a yearly influenza vaccination since August 1, 2016? NO ☐ YES ☐
   If yes, when? _____
2. Have you ever received a Pneumonia Vaccination? NO ☐ YES ☐

The next 2 questions are for women only.:

3. Age 21-64 years of age, have you received a Pap test to screen for cervical cancer? NO ☐ YES ☐
   If yes, when? _____
4. In the last 27 months have you had a mammogram to screen for breast cancer? NO ☐ YES ☐
   If yes, when? _____

****Upon signing this form you are acknowledging that you have given us a complete medical history.***
Patient or Guardian Signature:

_____ Date _____

Provider Signature _____ Date _____

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Acknowledgment of Notice of Privacy Practices

I, _____, acknowledge that I have received a printed copy of the Notice of Privacy Practices for Compass Health.

_____ _____
Patient Signature Date

Compass Health

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain 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 to maintain 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.

We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. A copy of a revised Notice of Privacy Practices may be obtained by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. If you have any questions about this Notice, please contact our Privacy Manager at 517-999-5900.

Your Rights Under The Privacy Rule

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. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines.

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 may 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 a 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.

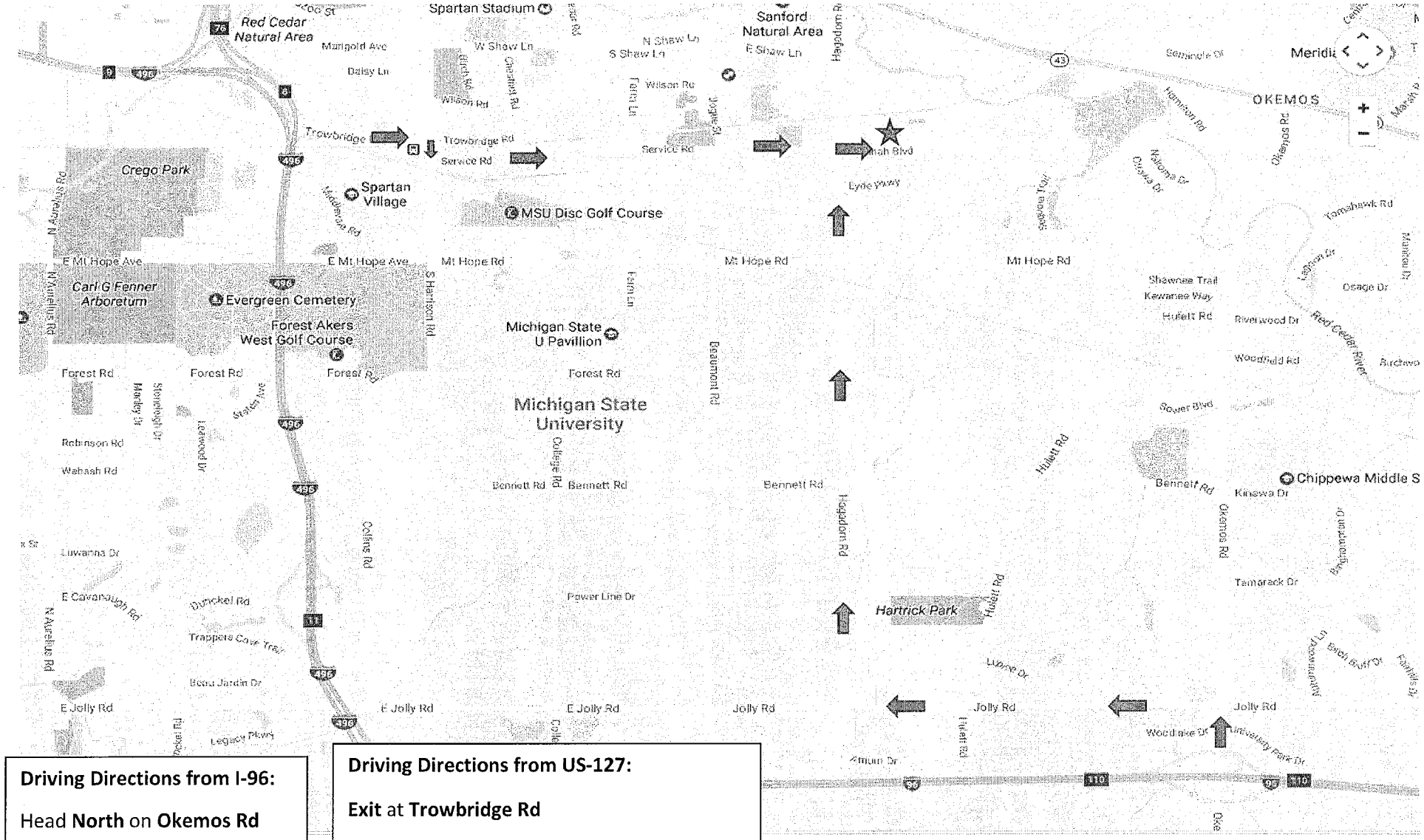
How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment - We may use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare 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 healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as; making a



Driving Directions from I-96:

Head **North** on **Okemos Rd**

Turn **Left** onto **Jolly Rd**

Turn **Right** onto **Hagadorn Rd**

Turn **Right** onto **Hannah Blvd**

Turn **Left** at **2900 Hannah Blvd**

Driving Directions from US-127:

Exit at **Trowbridge Rd**

Turn **Right** onto **Harrison Rd**

Turn **Left** onto **Service Dr**

Cross Hagadorn Rd; **Service Dr is now Hannah Blvd.** Turn **Left** at **2900 Hannah Blvd**

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