Orthopedic Surgery & Sports Medicine
Gary G. Doss, D.O.
Rajesh B. Makim, M.D.
Todd P. Murphy, M.D.

Hand Surgery
Steven J. Heithoff, D.O.

Joint Replacement Surgery
Scott M. Heithoff, D.O.

Foot and Ankle Surgery
William M. Braaksma, M.D.

Spine Surgery
E. Neil Pasia, D.O.

Physical Medicine
Matthew J. Sciotti, M.D.
Scott M. Kowalski, D.O.

Physician Assistants
Amy Collins, MS, PA-C
Jennifer Hodny, MS, PA-C
Josh Kiba, MS, PA-C
Adam Hoffman, PA –C

Physical Therapists
Maureen Muzzarelli, PT, DPT
Donna Grundman, DSc., PT, MS
Krista Marquardt, MPT, CHT
Marc Muzzarelli, PT, PSY. LLP

Physical Therapy Assistants
Karen Hallay, PTA
Kristin Pillon, PTA
Margaret Bales, PTA

Massage Therapists

Welcome to Orthopedic Associates of Port Huron

Thank you for choosing Orthopedic Associates for your musculoskeletal care. We have enclosed information to help you get acquainted with our facility. We have also included registration forms for you to complete prior to your office visit; this will expedite the registration process on the day of your appointment.

To help us serve you better, please bring the following items to your appointment:

- □ X-rays, including images and/or reports
- □ Test results, including MRI, CT scan, bone scan, etc.
- □ Insurance cards and Driver’s License
- □ Letters of referral and authorization
- □ **Completed** registration forms (enclosed)

Insurance mandates that all **deductibles and co-pays are due at the time of your appointment**, Orthopedic Associates does offer VISA, MasterCard, Discover, American Express, Care Credit, or automatic credit card withdrawal as methods of payment.

Your treatment is important to us. Feel free to contact the office should you have any questions prior to your appointment.

Sincerely,

Physicians and Staff
Orthopedic Associates of Port Huron, P.C.

940 River Centre Drive • Port Huron, Michigan 48060
Phone (810)985-4900 Fax (810)985-3634
Toll Free (888)OAPH-911 (888-627-4911)
www.oaph.com

ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C.
PATIENT INFORMATION

Patient's Name:______________________________ Age: _______ Birth Date: ☐☐/☐☐/☐☐
Address:__________________________________ Phone #: (____) - __________Cell # _____________
Sex: ☐M ☐F
City:__________________________ State:_______ Zip:______________

Social Security #:____________________________Primary Care Physician: _________________________
Marital Status: M☐ S☐ D☐ W☐ Sep☐ Email Address:______________________________________
Patient Employer:____
Employer's Address:____Business Phone #: (____) - _____
City:__________________________ State:______ Zip: _____________

Spouse's Name:____________________________ Spouse's Birth Date: ☐☐/☐☐/☐☐
Social Security #:___________________________ Spouse's Employer Name:_________________________
Email Address:______________________________ Employer Address:______________________________
City:________________________________ State:_______ Zip:______________

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name:____________________________________Birth Date: ☐☐/☐☐/☐☐
Social Security #:_____________________ Address:______________________________________
City:________________________________ State:_______ Zip:________ Home Phone #:(_______) - ______
Email Address:______________________________ Employer:____________________________________
Business Phone #: (____) - ___________ Employer Address: _________________________________

Father's Name:____________________________________ Birth Date: ☐☐/☐☐/☐☐
Social Security #:_____________________ Address:______________________________________
City:__________________________ State:_______ Zip:______________
Email Address:______________________________ Employer:____________________________________
Business Phone #: (____) - ___________ Employer Address: _________________________________

Authorization

I hereby authorize payment directly to ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C. for the surgical and/or medical services as described. I understand that I am responsible for payment of my bills and that my insurance will be billed for any payable benefits as a service to me.

I authorize the release of information regarding my condition, as necessary, to process these and/or related claims. I permit a copy of this authorization to be used in place of the original.

Signature:____ Date:___________________

ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C.
AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. **I hereby authorize ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C., to release my medical information to the following individual(s):**
   - ☐ Self
   - ☐ Spouse: ____
   - ☐ Parent(s): ____
   - ☐ Employer: ____
   - ☐ School: ____
   - ☐ Other: ____

2. **Specific information to be disclosed (check all that apply):**
   - ☐ Records of treatment including office notes and health history
   - ☐ Diagnostic testing
   - ☐ Digital X-ray films
   - ☐ Billing Statements
   - ☐ Other: ____

3. **I am requesting this information to be released for the following purpose(s):**
   - ☐ Continued Care
   - ☐ Insurance Claim
   - ☐ Personal Use
   - ☐ Other (Describe): ____

4. **I authorize all information which may be contained in my medical records at Orthopedic Associates of Port Huron, P.C. to be released unless otherwise specified here:** ______________________
   ____
   ____

5. **This authorization will automatically expire on: ____/____/____ (If no expiration date is listed this authorization will expire one year from the date of my signature.)**

I give permission for this information to be released via telephone, mail, facsimile, and/or e-mail. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

I further understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ORTHOPEDIC ASSOCIATES OF PORT HURON, P.C. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to medical information that is released for purposes of treatment, payment, and/or healthcare operations as outlined in OAPH's privacy notice.

____ ______________________
Patient Name (Print) Date of Birth

____ ______________________
Signature of Patient or Legally Authorized Representative (Agent) If Agent, Relationship to patient

____
Date