Branislav Behan, M.D.

2117 16th Street, Bay City, MI 48708
Telephone: 989-895-9500 Fax: 989-895-9600

Welcome to Dr. Behan's office. We would like to take this opportunity to welcome you to our practice and to thank you for choosing Dr. Behan as your Orthopedic Surgeon. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

Our office is open **Monday and Wednesday from 8:00am- 5:00pm, Tuesday and Thursday from 8:00am- 4:00pm, and Friday from 8:00am- 12:00pm.** Every effort is made to see our patients for medical problems during daytime hours.

Appointments
We strive to schedule appointments appropriately, emergencies can and do occur. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary. **If you need an appointment, please call during regular business hours. If you need a prescription refill, please allow up to 72 hours for approval. Please be courteous and do not wait to call.**

Cancellations
In order to be respectful of the medical needs of our patients please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is need of treatment.

Insurance
Dr. Behan accepts most insurance plans. If you have specific questions please contact your insurance company.
It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.

Payments
Patients are responsible for co-pays and past due balances at time of service, unless a prior agreement has been made with our billing department. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department. Dr. Behan accepts cash, personal checks, Visa and Mastercard. Checks can be made out to Dr. Branislav Behan.

Pain Medications
Our office is in compliance with Michigan State laws. We **do not** provide narcotics for long term pain relief. We kindly ask that you contact your family doctor for long term pain management or consult with a pain clinic.

Before your visit, please bring:
□ Insurance Card(s)
□ Picture ID or Driver's License
□ Enclosed Forms Completed
□ Medication/Allergy List
□ Surgical/ Past Medical History (if applicable)
□ Previous testing **reports and imaging discs** (including X-rays, MRI's, CT scans)
If you had testing at Mclaren Bay Region, it is not necessary to bring discs or reports.

Once again, we would like to thank you for choosing us. We look forward to working with you.

Sincerely,

Dr. Behan and Staff

Insurance Cards & Picture ID Copied □
Medication List Copied □

PATIENT REGISTRATION INFORMATION

PERSONAL INFORMATION: Today's Date_____

Marital Status: □ Single □ Married □ Divorced □ Widowed Sex: □Male □ Female

Name: _____ Nick Name: _____

Last Name First Name Middle Initial

Street Address: _____(Apt. #_____)

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Date of Birth: _____/_____/ _____ Social Security #: _____

Month Day Year

Spouse's Name: _____ May we discuss your medical info with spouse? □ Yes □ No

Primary Insurance: _____ Secondary Insurance: _____

Pharmacy of Choice: _____ Location: _____

Is it ok for our office to check your medications online and/or send prescriptions electronically? □ Yes □ No

Employment Status: □ Student □ Employed □ Retired □ Disabled

Employer Name (if applicable): _____

Is your condition a result of a work injury? □ Yes □ No An automobile accident? □ Yes □ No

If yes, date of injury: _____

If job related, person authorizing care: _____

Phone: (_____) _____ Case #: _____

It is ok to leave a message on your voicemail? □ Yes □ No May we contact you at work? □ Yes □ No

Reason for Visit: _____

REFERRAL INFORMATION:

How did you hear of us? _____ □ Friend □ Doctor □ Family □ Other

Family Doctor: _____ Phone: (_____) _____

Cardiologist: _____ Phone: (_____) _____

Dentist: _____ Phone: (_____) _____

EMERGENCY CONTACT:

Name of Contact: _____ Relationship: _____

Home Phone: Phone: (_____) _____ Work Phone: (_____) _____

PATIENT MEDICAL HISTORY

Height: _____foot _____ inches Weight: _____ pounds

SURGICAL HISTORY:

Have you had any surgeries? □ Yes □ No

Type of Surgery Approximately When? City/Hospital? Name of Surgeon?

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

LIST OF MEDICATIONS:

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6			13.		
7.			14.		

SOCIAL HISTORY:

Do you currently drink alcohol? □ Yes □ No If yes, how often? □ Daily □ Weekly □ Socially

Do you currently smoke cigarettes/cigars? □ Yes □ No □ Never Quit Date: _____

If yes, how many cigarettes per day? □ Less than 10 cigarettes □ 1/2 pack □ 1 pack

□ 1 and ½ packs □ 2 packs □ 3 packs

Number of Years Smoked: _____

Do you currently use illegal drugs? □ Yes □ No □ Only in past

DRUG/ ENVIRONMENTAL ALLERGIES:

*****Are you allergic to latex? □ Yes □ No**

Allergy	Reaction	Allergy	Reaction
1.		4.	
2.		5.	
3.		6.	

MEDICAL PROBLEMS:

Please check box if you currently have or have had this health condition in the past.

Do you have heart problems? □ Yes □ No If yes, are you currently seeing a cardiologist? □ Yes □ No

Do you have diabetes? □ Yes □ No What type? □ Type 1 □ Type 2 □ Pre-diabetic

Are you taking insulin? □ Yes □ No

Have you had a history of blood clots? □ Yes □ No

Are you taking any blood thinners? □ Yes □ No Are you taking Aspirin? □ Yes □ No

If yes, please list: _____

Do you have a history of MRSA? □ Yes □ No

1. AIDS/ HIV?	□ Yes	□ No	9. Cancer?	□ Yes	□ No
2. Anemia?	□ Yes	□ No	10. High Cholesterol?	□ Yes	□ No
3. Gout?	□ Yes	□ No	11. Thyroid Problems?	□ Yes	□ No
4. COPD/ Emphysema?	□ Yes	□ No	12. A-Fib?	□ Yes	□ No
5. High Blood Pressure?	□ Yes	□ No	13. Anxiety?	□ Yes	□ No
6. Low Blood Pressure?	□ Yes	□ No	14. Depression?	□ Yes	□ No
7. Heart Attack?	□ Yes	□ No	15. Alzheimer's?	□ Yes	□ No
8. Kidney Disease?	□ Yes	□ No	16. Osteoporosis?	□ Yes	□ No

17. Other? (Please List): _____

FAMILY HISTORY:

Are you adopted? □ Yes □ No

Mother: □ Alive □ Deceased

Health Problems? □ Unknown □ Heart Disease □ Cancer □ Stroke □ Diabetes □ Other: _____

Father: □ Alive □ Deceased

Health Problems? □ Unknown □ Heart Disease □ Cancer □ Stroke □ Diabetes □ Other: _____

Sibling: □ Alive □ Deceased

Health Problems? □ Unknown □ Heart Disease □ Cancer □ Stroke □ Diabetes □ Other: _____

Sibling: □ Alive □ Deceased

Health Problems? □ Unknown □ Heart Disease □ Cancer □ Stroke □ Diabetes □ Other: _____

AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION:

Please list any family members, friends, organizations, and/or physicians that it is ok for our office to disclose your medical information to.

Name of Contact	Relationship	Name of Contact	Relationship
1.		4.	
2.		5.	
3.		6.	

ASSIGNMENT AND RELEASE:

I certify that I, and /or my dependent(s), have insurance coverage (with the insurance that I have provided this office copies of) and assign directly to Dr. Branislav Behan M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to my Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Also, I understand that if Dr. Behan does not participate with my insurance, I accept full responsibility for my balance. I accept full responsibility for my balance that my insurance may not cover in full.

_____ _____

Patient's Signature or Patient's Representative Date

I authorize that all information I have provided is accurate and true to the best of my knowledge.

_____ _____

Patient's Signature or Patient's Representative Date

_____

Printed Name of Patient

Dr. Branislav Behan
Orthopedic Surgeon
www.BehanOrthoClinic.com

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HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care prodders to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect our privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to our Patients), to request restrictions and revoke consent in writing.

❑ I have accepted this HIPAA information to me

❑ I have declined this HIPAA information given to me

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Patient Consent for the Use and Disclosure of Protected Health Information

This is my consent for DR. BRANISLAV BEHAN to use and disclose my protected health information to carry out treatment, payment and healthcare operations. This is my acknowledgement that I may view DR. BRANISLAV BEHAN's Notice of Privacy Practices.

This is my consent for **DR. BRANISLAV BEHAN** to:

☐ Call my home and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information. We have an automated service that will call and remind you of your appointment date and time.

☐ Call and leave reports of my clinical care, lab results.

☐ Email me using my personal or other designated email address with appointment reminders and other matters related to my clinical care.

☐ Mail items that assist in carrying out my treatment, payment, or health questions, such as patient statements to my home or other designated location

This is my consent for information regarding my general health and treatment to be discussed with the following people, please print their name and telephone number

_____

_____

This is my consent for information regarding my health and treatment to be discussed with the following people in the event of an emergency, please print their name and telephone contact number:

_____

_____

By signing this form, I am consenting to **DR BRANISLAV BEHAN** use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except on those disclosures made prior to my consent. I understand that **DR. BRANISLAV BEHAN** reserves the right to refuse to treat me if I do not sign this consent form.

_____ _____

Patient's Name Please Print Date

_____ _____

Signature of Patient or Legal Guardian Date

Dr. Branislav D. Behan

Orthopedic Surgeon

2117 16th Street Bay City, MI 48708

989-895-9500 phone 989-895-9600 fax

CONSENT FOR OPOIDS (Narcotic) MANAGEMENT FOR CHRONIC NON-CANCER PAIN

Dr. Branislav Behan, M.D. _____ Name of Patient

The above named physician from Dr. Branislav Behan, M.D., will manage your chronic pain. The goal is to improve your functional ability. The important risks and side effects are listed below as follows:

1. Sedation, drowsiness, sleepiness
2. Confusion, change in thinking ability
3. Difficulty with balance and judgment which may make it unsafe to operate heavy equipment or motor vehicles
4. Constipation, nausea, vomiting
5. Decreased respirations or breathing
6. Physical dependence, which means that if you abruptly stop taking this medication, you may begin withdrawal. Signs of withdrawal include diahhrea, abdominal cramping, "goose bumps", flu-like symptoms, anxiety
7. Psychological dependence or addiction
8. Risks during pregnancy, children born to mothers on opioids are likely to be physically dependent to the drug at birth

The above named physician is willing to provide treatment with opioids (narcotics) under the following guidelines and conditions:

1. Other reasonable non-opioid treatment measures have been ineffective or have produced intolerable side effects
2. The patient does not have a current problem of substance abuse or dependence
3. The patient has never been involved in the sale, diversion, illegal possession or transport of controlled substances including narcotics, sleeping pills, nerve pills, and/or pain killers.
4. The patient will obtain all narcotic prescriptions only from Dr. Branislav Behan, M.D.
5. The patient will not seek narcotic prescriptions from any other physicians other than Dr. Branislav Behan
6. The patient will only take medications only as prescribed and under no circumstances allow any other individual to take these prescriptions
7. The patient allows Dr. Branislav Behan's staff to communicate with the referring physicians, pharmacists, as well as the Police Department or Drug Task Force, regarding the use of narcotics
8. The patient will follow the advice of Dr. Branislav Behan, M.D. in regards to stopping controlled substances if it is felt necessary.
9. The patient consents to unannounced blood/urine screening tests and random pill counts in order to properly assess the effects of narcotics and patient compliance
10. If the patient is a female of child bearing age, the patient confirms that she is not pregnant and will take appropriate measures to prevent pregnancy during the course of treatment
11. The patient agrees to the other services including professionals from chemical dependency, psychiatry and behavioral services prior to and during treatment.
12. The patient agrees to comply with the total treatment plan including other modalities of treatment (i.e. nerve blocks, physical therapy, psychological counseling, etc.) as deemed necessary
13. The patient will keep all appointments with Dr. Branislav Behan, M.D.

14. The patient understands that no allowance will be made for lost prescriptions
15. Should the patient believe that she/he requires more opioids (narcotics) than have been prescribed, she/he must contact Dr. Branislav Behan, M.D. prior to increasing the dose. Prescriptions will not be given early
16. If the patient goes to an emergency room or hospital, the patient will inform the doctor in charge of the existence of this opioid contract.

The patient understands that this treatment will be discontinued if any of the following occur:

1. Pain is not effectively managed with the use of opioids
2. Patient gives away, sells or misuses the drugs
3. A rapid tolerance of loss of effect from the opioids occurs
4. Side effects become intolerable or dangerous
5. Patient obtains opioids from any source other than Dr. Branislav Behan, M.D.
6. Drug screening test positive for illicit or recreational drugs i.e. cocaine, marijuana, etc.

If we choose to discontinue your opioid treatment, we will gradually lower the dose over several days to avoid withdrawal. If your physician feels that you have a dependence problem, we may refer you elsewhere for the management of chemical dependency and detoxification.

I have read this document, understand it and have had all my questions answered satisfactorily. I consent to the use of opioids (narcotics) to help control my pain and understand that the treatment will be conducted in accordance with the conditions stated above.

Patient (Printed Name)	Physician (Printed Name)	Date Signed
	Dr. Branislav Behan, M.D.	
Patient Signature	**Physician Signature**	**Date Signed**
	Branislav D. Behan, MD	