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, your patient centered home medical neighborhood. We will partner with your Primary Care Physician (PCP) by sharing limited or long-term management of your healthcare and provide advice, guidance and periodic follow up throughout your treatment.

Our office is open **Monday from 8:00am-3:00pm, Tuesday and Thursday 8:00am-2:30pm, and Wednesday and Friday from 8:00am- 3:30pm.** Please log on to our patient portal www.BehanOrthoClinic.com to create your portal account, see staff for password.

Our office will work with your PCP in the following ways:

- Communicate with your PCP and provide them with timely written reports as they relate to you.
- Notify your PCP of cancellations, no shows, and other actions that may place your care in jeopardy.
- Schedule a follow-up appointment for you with your PCP or assist you in scheduling an appointment with a PCP who is accepting new patients.

We trust you, our patient to be actively engaged in your care and assist us in providing the best care possible by:

- Tell us what you know about your health, illnesses, your needs and your concerns.
- Take part in the care plan that is agreed upon and let us know why you cannot so that we may assist you.
- Seek the advice of your PCP before you see other physicians and identify any physician who is currently treating you, to your PCP and this office.
- See your physician on an annual basis for all preventive services.
- Share any updates on medications, dietary supplements or remedies you are using and any questions you may have about taking them.
- Please request prescription refills 2 business days in advance of needing a refill.
    - If you need assistance for: transportation to our practice, prescription assistance, community services — dial 211 from any phone and you will be connected to a referral hotline that will assist you.

If You Need After Hours Care: If it is related to what this office is treating you for call 989-895-9500 to reach our answering service or If you need medical attention for any other condition, contact your Primary Care Physician. Emergencies call 911.

Payments

Patients are responsible for co-pays, deductibles, and all balances due at the 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 personal checks, Visa and MasterCard. Checks can be made out to Dr. Branislav Behan. We also charge for completion of disability/Work Comp paperwork, the fee is $30.00.

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 including 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.

Sincerely,
Dr. Behan and Staff

PCMH ☐

NEW 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

EMERGENCY CONTACT:

Name of Contact: _______________________________________ Relationship: _____________________________

Home Phone: (_________) ___________________________ Work Phone: (_________) _______________________

INSURANCE:

Primary Insurance: ______________________________ Secondary Insurance: _______________________________

Ins. Subscriber: _____________________________________ Subscriber's DOB: _____________________________

PHARMACY:

Pharmacy of Choice: ________________________________ Location: ______________________________________

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

EMPLOYMENT:

Employment Status: ☐ Student ☐ Employed ☐ Retired ☐ Disabled

Employer Name (if applicable): ____Phone________________________

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 #: ____

REFERRAL INFORMATION:

Reason for Visit: ____

How did you hear of us? __________________________ ☐ Friend ☐ Doctor ☐ Family ☐ Other

Family Doctor: ____ Phone: (_________) ____________________________

Cardiologist: ____ Phone: (_________) ____________________________

Dentist: ____ 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.		

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: ____________

SOCIAL HISTORY:

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 *# of Years Smoked*: ________

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

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

DRUG/ ENVIRONMENTAL ALLERGIES:

☐ NO KNOWN 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): ____

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, Third Party agencies, and collection agencies, 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 be covered in full.

____ ____________________

Patient's Signature or Patient's Representative Date

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help ensure 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.

Patient Consent for the Use and Disclosure of Protected Health Information

This is my consent for BRANISLAV BEHAN M.D. **to use and disclose my protected health information to carry out treatment, billing, payment, third party agencies, collection agencies, 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/cell and leave a message on voicemail or in person to remind me of appointments, or obtain insurance information, other notice/information.

☐ Mail items that assist in carrying out my treatment, billing, payment, third party agencies, collection agencies, or health questions, such as patient statements to my home or other designated locations.

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

Name	Relationship	Phone Number

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

☐ I have accepted this HIPAA information by signing below

☐ I have declined a copy of this HIPAA information to be given to me

____

Patient's Name Please Print

____ __________________________________

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

The above-named physician, 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 respiration 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 on 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 regard 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 accurately assess the effects of narcotics and patient compliance.
10. If the patient is a female of childbearing age, the patient confirms that she is not pregnant and will act appropriately to prevent pregnancy during 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. Patients obtain 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.

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

I am currently a patient of a Pain Clinic: ☐ Yes ☐ No ____

And/or

I am currently receiving pain medications from my Family Physician: ☐ Yes ☐ No ____________________

____

OUR PATIENT PORTAL IS NOW AVAILABLE

www.behanorthoclinic.com

Please go to our website on your computer or Smartphone. Click on the Patient Portal tab in the upper right-hand corner of your screen.

We will supply you with your password. Your sign-in name is your FIRST and Last name. You can now update your demographics, medical history, see upcoming appointments & request medication refills!

SIGN IN:

PASSWORD: