

Grand River

SURGERY

Dear _____,

You are scheduled for a consultation at Grand River Surgery.

Vascular Surgery

John T. Morris, DO
Joseph G. Sage, DO

Open and
Endovascular Surgery

Therapeutic and
Cosmetic Vein Care

MetroHealth Campus
2093 Health Dr, Suite 300
Wyoming, MI 49519
Ph: 616/532-8100
Fx: 616/532-8200

Saint Mary's Campus
310 Lafayette SE, Suite 301
Grand Rapids, MI 49503
Ph: 616/685-6900
Fx: 616/685-8950

Sheridan Community Hospital
301 N. Main
Sheridan, MI 48884
Ph: 989/291-3261

Date: _____ Arrival Time: _____ Appointment Time: _____

Doctor: Joseph Sage, DO John Morris, DO

Location: Metro Village, 2093 Health Dr • Suite 300 • Wyoming 49519
 Saint Mary's, 310 Lafayette • Suite 301 • Grand Rapids 49503
 Sheridan Community Hospital, 301 N. Main • Sheridan 48884

Please **COMPLETE** the enclosed paperwork and bring this with you to your appointment, the doctor can not see you until the paperwork is complete. You must also bring your Insurance Cards, Driver's License and a list of any medications that you are on with the dosages. As healthcare professionals, it is our goal to give you the best quality care possible. This letter is to provide you with important information you will need prior to arriving at our office. If you are unable to make your scheduled appointment, please contact us at least 24 hours in advance to cancel or reschedule.

We do participate with most insurance companies, however, please be aware of your coverage and verify with your insurance company that we are a participating provider. If you are a member of an HMO that requires authorization from your primary care physician, please be sure to obtain the necessary authorization forms and bring them with you to your appointment. If you have Medicaid with a Spend Down or Deductible please contact your case worker to see if has been met for the month, if not please plan on paying it prior to seeing the doctor.

All co-pays and deductibles must be paid at the time of service. If you do not have insurance coverage or if we do not participate with your insurance, payment in full is expected at the time of your visit, unless prior arrangements have been made. Consultations range from \$170.00 to \$311.00. For your convenience, we accept cash, checks, Visa, and MasterCard.

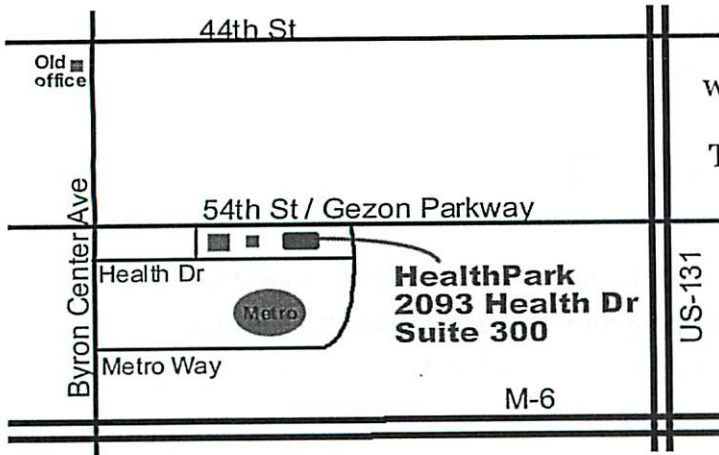
If you have any questions regarding the above information or what to expect at your visit, please do not hesitate to call us at the number below. We look forward to meeting and providing care to you.

Sincerely, Grand River Surgery



Extracranial Cerebrovascular
Peripheral Arterial
Peripheral Venous

**Metro Village Location
2093 Health Dr, Suite 300
Wyoming, Michigan 49519
616 - 532 -8100**



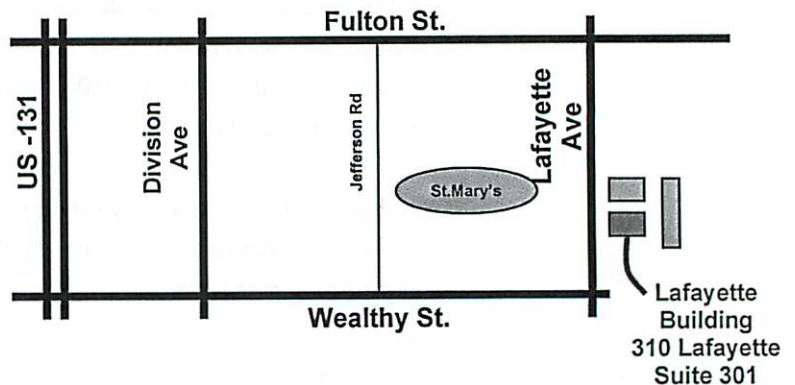
From any direction, go to M-6 which intersects with I-96, US-131 and I-196. From east of US-131, go west on M-6; from west of US-131, go east on M-6. Take the Byron Center Rd exit and go north. Stay in the rightmost lane, this will become a turn right only lane onto Health Drive. 2093 is the HealthPark Building beyond the four-way stop. Patient parking is on the east end of the building, look for the overhang over the patient drop-off circle. Our office is on the third floor.

**St. Mary's Office Location
310 Lafayette Ave, Suite 301
Grand Rapids, MI 49503
616-685-6900**

From the North: Take US-131 to Wealthy St. Turn Left (East). Turn Left on Lafayette Ave.

From the South: Take US-131 to Wealthy St. Turn Right (East). Turn Left on Lafayette.

There is covered parking behind the building. Enter through the main atrium and go left.



Joseph G. Sage, D.O.
John T. Morris, D.O.

Grand River

SURGERY

PATIENT INFORMATION

Phone:(616) 532-8100 Fax: (616)532-8200
2093 Health Dr, Suite 300
Wyoming, MI 49519
Phone: (616)685-6900 Fax:(616)685-8950
310 Lafayette Ave, Suite 301
Grand Rapids, MI 49503

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please print. All information will be kept confidential.

Patient's Full Name _____

Street Address _____ Apt / Lot # _____

City _____ State _____ Zip _____

Social Security # _____ Male [] Female [] Birthdate _____ Age _____

Marital Status: [] Minor [] Single [] Married [] Widowed [] Divorced Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Race _____ Ethnicity _____

Preferred Language _____

Employer _____ Employer's Address _____

Which Physician referred you? _____

Primary Care Physician _____ PCP Phone _____

Person to contact in case of emergency _____

Relationship _____ Contact Phone #'s _____

Next of kin (not living with you) _____ Phone _____

Responsible Party

Name of person responsible for this account (if not self) _____

Relationship to Patient _____ Home Phone _____

Employer _____ Work Phone _____

Insurance Information

Primary Insurance Co. _____ How much is your copay? _____

Policy Holder _____ Birthday of insured _____ Relationship to patient _____

Secondary Insurance Co. _____ How much is your copay? _____

Policy Holder _____ Birthday of insured _____ Relationship to patient _____

Pharmacy Information

Name of Pharmacy _____ Phone # _____

Location: _____

I authorize payment of medical benefits by the insured directly to Grand River Surgery PLC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to me /my child (if the patient is a minor) and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize Grand River Surgery PLC to release any information required to process my / my child's claim. I understand that any default in payment may result in placement with a collection agency or the use of the judicial system. I agree to be responsible for any collection, legal and/or attorney fees associated with collecting my account balance. This request shall remain in effect until revoked by myself in writing.

Signature _____ Date _____

Grand River

SURGERY

Prescription Renewal Policy

Vascular Surgery

John T. Morris, DO
Joseph G. Sage, DO

Open and
Endovascular Surgery

Therapeutic and
Cosmetic Vein Care

MetroHealth Campus
2093 Health Dr, Suite 300
Wyoming, MI 49519
Ph: 616/532-8100
Fx: 616/532-8200

Saint Mary's Campus
310 Lafayette SE, Suite 301
Grand Rapids, MI 49503
Ph: 616/685-6900
Fx: 616/685-8950

Prescriptions are renewed during normal office hours, which are 8:00 AM to 5:00 PM, Monday – Friday. Refills generally take between 24 - 48 hours to be processed. If you have questions about how to take your prescription, please do not hesitate to call the office. One of our staff members will answer your questions, or if necessary, talk with the physician and get back to you promptly. Renewal requests received after hours are subject to an after-hours fee. If at any time you are in need of a new medication, please contact our office. In the event the office is closed, the physician on call will call you back to determine your medication needs.

FMLA Form Completion and/or Revision Policy

A \$15.00 *per form* fee is payable prior to the provider and/or staff completing or revising a Family Medical Leave Act (FMLA) form. The individual requesting the completion of the form will be required to pay the fee prior to the form's completion. The staff will notify the individual when the form has been completed and is ready for pickup.

Short-Notice Cancellation / No Show Policy

The providers of Grand River Surgery PLLC understand that a patient may, on occasion, miss their appointment time due to unforeseen circumstances. However, patients who chronically no show, cancel or reschedule appointments *less than 24 hours prior* to their appointment time will be charged a nominal fee. If a patient misses their appointment, cancels or reschedules their appointment *less than 24 hours prior* to their appointment time twice, with any combination of providers within our office, they will be charged a \$25 fee on the third occurrence and every occurrence thereafter. This fee will not be submitted to any insurance carrier and is payable prior to scheduling further non-urgent appointments within our practice.

Elective Surgery

Sheridan Community Hospital A non-refundable cancellation fee of \$50.00 will be assessed to any patient scheduled for an elective surgery who cancels their surgery less than 48 hours in advance (during routine business days and hours) or who does not show up for their procedure. This fee must be paid prior to surgery being re-scheduled. If the patient does not give a minimum of 48 hour notice to cancel surgery or does not show up for their procedure a second time, an additional \$100.00 non-refundable cancellation fee will be assessed and must be paid prior to rescheduling their procedure. If it happens a third time, the patient will be discharged from the practice. These non-refundable cancellation fees are not billable to or payable by any insurance carrier including any Federal, State or government benefit programs. By not presenting for a surgery or providing reasonable notice of cancellation, you're preventing another patient from having the opportunity to have their procedure.



Extracranial Cerebrovascular
Peripheral Arterial
Peripheral Venous

Patient / Guardian Signature

Date

Revised 06/20/11

Joseph G. Sage, D.O.
John T. Morris, D.O.

Grand River SURGERY

Phone:(616) 532-8100 Fax: (616)532-8200
2093 Health Dr, Suite 300
Wyoming, MI 49519
Phone: (616)685-6900 Fax:(616)685-8950
310 Lafayette Ave, Suite 301
Grand Rapids, MI 49503

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Medical information about you is confidential. In order to discuss or answer questions about your health with anyone, such as your spouse/significant other, adult child, etc., we need your permission. If you choose, you may indicate that you do not want us to discuss your medical information with anyone by writing "NONE" on one of the lines below and signing this form.

Optional:

Please print your password _____. If you choose a password, those individuals listed on this form, must state your password in order to receive information.

I authorize Dr. Sage, Dr. Morris and their associates to release medical information about me to the following individuals:

Name:

Relationship:

If there is any information in your medical record you **DO NOT** want discussed with or released to the above named individuals, such as information related to sexually transmitted infections, drug or alcohol abuse, and/or mental health status, please state what information you wish to have **excluded**:

This authorization does not expire until it is revoked in writing. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand it is my responsibility to inform this office in writing if I wish to revoke an individual's access to my protected health information.

Patient/Guardian Signature

Date

Grand River

SURGERY

Vascular Surgery

John T. Morris, DO
Joseph G. Sage, DO

Open and
Endovascular Surgery

Therapeutic and
Cosmetic Vein Care

Notice and Acknowledgment

Acknowledgment.

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

MetroHealth Campus
2093 Health Dr, Suite 300
Wyoming, MI 49519
Ph: 616/532-8100
Fx: 616/532-8200

X _____

Signature of Patient or Representative

_____ Date

Saint Mary's Campus
310 Lafayette SE, Suite 301
Grand Rapids, MI 49503
Ph: 616/685-6900
Fx: 616/685-8950

Relationship to Patient, if signed
by a Representative

Sheridan Community Hospital
301 N. Main
Sheridan, MI 48884
Ph: 989/291-3261



Extracranial Cerebrovascular
Peripheral Arterial
Peripheral Venous

Grand River Surgery Outpatient History

Patient's Name: _____
 Date of Birth: _____
 Referring Doctor: _____
 Appointment Date: _____

Reason for Visit:

Medical History

Diabetes Mellitus, how long _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Pregnancies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Elevated Cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stomach Ulcers or Reflux (GERD)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many pregnancies and how many live births?	Births	Preg	
Heart Attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Liver Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever worn compression stockings? If so, for what duration? Did they help?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Congestive Heart Failure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Months _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bleeding Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes				

Previous Surgeries	(<input type="checkbox"/> if none)	Date:	Anesthesia Problems: (<input type="checkbox"/> if none)

Current Medications			Allergies	
Medication	Dose	Times Taken	Do you have any allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Family History				Social History		
	Age	Age Died	Illnesses	Alcohol, amount	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Mother				Tobacco, amount	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Father				Illicit Substance Use	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Brother				Retired	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sister				Occupation		

Please complete both sides.

Name: _____ Date of Birth: _____

Review of Systems

Constitutional

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Unexpected Change in Weight
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Weakness
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Fatigue
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Unexplained Fevers, Sweats, or Chills
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Difficulty Sleeping

Cardiovascular

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chest Pain
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Shortness of Breath
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Leg Swelling
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Irregular Heart Rhythm
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Passing Out

Respiratory

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Wheezing
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chronic Cough
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood in Sputum
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Recent Change in Breathing
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Use Oxygen

Genitourinary

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Urinary Frequency
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Painful Urination
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Difficulty Urinating
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood in Urine

Hematological (Blood)

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Abnormal Bleeding
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Bruising
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anemia
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Blood Clotting Disorder

Psychiatric

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Depression
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anxiety
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mood Changes
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Alcohol Abuse
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Drug Abuse

Gastrointestinal

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Abdominal Pain
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Change in Bowel Habits
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Nausea
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Vomiting
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diarrhea
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Constipation
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Black or Bloody Stool
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heartburn

Skin and Breast

<input type="checkbox"/> No	<input type="checkbox"/> Yes	New Breast Lump/Mass
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Breast Pain
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Nipple Discharge
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Unusual Itching
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Rash
<input type="checkbox"/> No	<input type="checkbox"/> Yes	New Skin Lesion
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Color Changes
<input type="checkbox"/> No	<input type="checkbox"/> Yes	New Sores

Neurological

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Numbness
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tingling
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tremors
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Chronic Headaches
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Memory Loss

Musculoskeletal

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Backache
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Muscle cramps
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Extremity Pain
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Extremity Weakness
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Joint Pain
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Joint Swelling