www.MichiganHerniaSurgery.com
General, Laparoscopic, and Robotic Surgery, Hernia and Abdominal Wall Reconstruction

Randy Janczyk, M.D., FACS   Anthony Iacco, M.D., FACS

Patient Name:______________________________Height:___________Weight_______

Primary Doctor Information

Your Primary Doctors Name: ____________________________Phone:______________

Address:____

City:_______________________________________State:________Zip:____________

Privacy Policy

A copy of our notice of privacy practices policy will be available to review at your initial office visit. It may be requested in person, by mail, phone or fax.

Forms Policy

One set of forms (FMLA, Disability, Return to work, etc), will be completed free of charge. Any subsequent changes or additional forms will each be subject to a $30.00 charge, which must be paid prior to form completion. This fee does not ensure you will obtain disability, time off, or other desired outcomes. Form completion may require up to 10 business days. We are happy to work with you as we know this process can be difficult.

Signature:____Date:____________

3535 West Thirteen Mile Road, Suite 204, Royal Oak, MI 48073   Ph: 248 551 9090   Fax: 248 551 9080

Protected Health Information Release Form:

Patient Name: ______________________________ Date: ______________

(1) Concerning matters of my health, I give permission for Dr. Iacco / Dr. Janczyk or a member of his staff to speak with:

Name of person(s) __________________ relationship to patient ______________

Name of person(s) __________________ relationship to patient ______________

2) I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

____

I authorize Dr. Iacco, Dr. Janczyk and their staff to contact me regarding my health care via: (information may include, but is not limited to, procedure scheduling, testing, results, medical clearance, wound care or photos, FMLA, disability, return to work or insurance paperwork)

Cell:________________ Home:______________ Fax:__________________

Email:________________________ Relationship if number not patients:__________

Signature of patient: ____________________________ Date:______________

AUTHORIZATION FOR RELEASE OF MEDICAL PHOTOGRAPHS

Medical photographs of your hernia and/or wounds may be taken before, during, or after a surgical procedure or treatment in order for us to track your condition/progress and aid in your care. Photos will not contain your name, face or other identifiable features so as to maintain your privacy.

1. CONSENT FOR RELEASE FOR PHOTOGRAPHS

I hereby authorize Randy Janczyk M.D./Anthony Iacco M.D., and/or their associates to take and use preoperative, intra-operative, and postoperative photographs for professional medical purposes.

Signature: ________________________________ Date: ____________

Dr. Randy Janczyk, M.D., FACS **MICHIGAN HERNIA SURGERY** Dr. Anthony Iacco, M.D., FACS

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

How did you hear about us? (Please check one box) ☐ Dr. ______ ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Web ☐ Other ______

Other Family Members Seen Here ______

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	☐ Yes ☐ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other ______

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other ______

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Michigan Hernia Surgery or my insurance company to release any information required to process my claims.

X ______

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER:______ E-MAIL______