

Jaret A. Beane, D.O.
Joseph G. Sage, D.O.
Kenneth D. Minks, M.D.
Rachel Dickerson, N.P.



Phone: (616) 532-8100
Fax: (616) 532-8200
2093 Health Dr, Suite 300
Wyoming, MI 49519

PATIENT INFORMATION

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 Separated Email Address _____

Home Phone _____ Cell / Pager # _____ Work Phone _____

Employer _____ Employer's Address _____

Whom may we thank for referring you? _____

Primary Care Physician _____ PCP Phone _____

PCP Address _____

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? _____

Contract ID # _____ Group # _____

Policy Holder _____ Birthday of insured _____ Relationship to patient _____

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

Contract ID # _____ Group # _____

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

Jaret A. Beane, DO
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Kenneth D. Minks, MD
Rachel Dickerson, NP
Jennifer London, LLPC
Katie Throop, RD

Jaret A. Beane, DO
Kenneth D. Minks, MD
General Surgery
-Advanced Laparoscopy
-Endoscopy

Joseph G. Sage, DO
Vascular Surgery
-Open and
Endovascular Surgery
-Therapeutic and
Cosmetic Vein Care

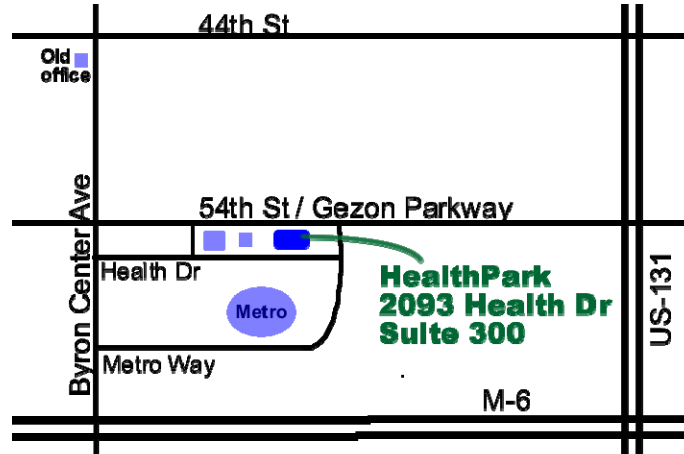
Advanced
Wound Care

Comprehensive
Lap-Band Program
& Placement
- Support Sessions
- Dietary Counseling
- Exercise instruction
in partnership
with area YMCA's

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www.grsurgery.com



2093 Health Dr, Suite 300 – Wyoming, Michigan – 49519
616 – 532 -8100

Use our website for exact turn-by-turn directions.

From any direction, go to M-6 (South Beltline) which intersects with I-96, US-131 and I-196. From or east of US-131, go west on M-6; from west of US-131, go east on M-6. Take the first exit (Byron Center Road) and turn right (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.



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Elective Surgery Cancellation Policy

A non-refundable cancellation fee of \$50.00 will be assessed to any patient scheduled for an elective surgery or an endoscopic procedure 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.

Prescription Renewal Policy

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.

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.

_____	_____
Patient/Guardian signature	Date
_____	_____
Witness	Date

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PATIENTS'S 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.

Please print your password _____. Those individuals listed on this form, must state your password in order to receive information.

I authorize Dr. Beane, Dr. Sage, Dr. Minks or Rachel Dickerson 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

Witness

Date



Grand River
SURGERY

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Notice and Acknowledgement

Acknowledgement:

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

Signature of Patient or Representative

Date

Relationship to Patient, if signed
by a Representative

Grand River Surgery Outpatient History & Physical

Name: _____

Date of Birth: _____

Referring Doctor: _____

Appointment Date: _____

Please complete both sides.

Chief Concern & History:

Current Medications	Medication	Dose	Times Taken

ALLERGIES	Do you have any allergies?	List Items Allergic to:
	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	

Medical History – please fill out completely

Diabetes Mellitus, how long _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer, including leukemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Other Serious Disease _____	<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	Pregnancies? If yes, how many pregnancies and how many live births?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Liver Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Births	Preg
Heart Attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you had a Colonoscopy or EGD?	<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 _____		

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

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

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

Physician Signature: _____ Date: _____