

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire in full. It will become part of your permanent record.

Name _____ Date of Birth ____/____/____ Female Male

Street Address _____ City _____ State _____ Zip _____

Social Security # ____-____-____ Phone #s: Home () _____ Work () _____ Cell () _____

E-mail _____ I would like to receive e-newsletters and e-mail specials.

Marital Status: M Spouse's Full Name _____ S D W # of Children ____ Ages _____

Occupation _____ Employer _____

How did you hear about CAM? _____ If referred, by whom? _____

What is your major health complaint? _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? Yes No

Do any positions make it feel worse? No Yes Explain _____

Do any positions make it feel better? No Yes Explain _____

Is this condition: Improved Unchanged Getting Worse?

Is this condition interfering with your: Work Sleep Daily Routine Other ? _____

Name other doctors or therapists who have treated this condition _____

List surgical operations and dates _____

Family Physician Name _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

List medications _____

Have you been in an auto accident or had any other personal injury? No Yes Describe _____

Patient Signature _____ Date ____/____/____

Parent or Guardian Signature _____ Date ____/____/____

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)

Warren, MI 48088

<http://www.chirowarren.com/>

A non-partnership of independent practitioners

586 / 293 - 4440 • Fax 586 / 293 - 0840





CHIROPRACTIC ASSOCIATES OF MICHIGAN / 31850 Schoenherr / Warren, MI 48088 / Ph. 586.293.4440 / Fax 586.293.0840
<http://www.chirowarren.com/>

A non-partnership of independent practitioners

REVIEW OF SYSTEMS - Check only the symptoms you have now, or have had in the past.

Patient Name _____ Date ____/____/____ Signature _____

	Current	Past		Current	Past		Current	Past
GENERAL			THROAT			GASTROINTESTINAL		
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
SKIN			NECK			Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	BREASTS			Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
HEAD			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Nipples	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam	____/____/____		Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	LUNGS			Burning	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Urine Color _____		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HEART			Periods	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type _____		
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Age of 1st Period ____/____/____		
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD			Duration of Cycle _____		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	# of Pregnancies _____		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	# of Births _____		
MOUTH			Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>	# of Miscarriages _____		
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	# of Abortions _____		
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light		
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Last Period ____/____/____		
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Pap Smear ____/____/____		
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam ____/____/____		
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>				Last Mammogram ____/____/____		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>						
Blisters	<input type="checkbox"/>	<input type="checkbox"/>						



CHIROPRACTIC ASSOCIATES OF MICHIGAN / 31850 Schoenherr / Warren, MI 48088 / Ph. 586.293.4440 / Fax 586.293.0840
<http://www.chirowarren.com/>
 A non-partnership of independent practitioners

REVIEW OF SYSTEMS - Page 2

Patient Name _____ Date ____/____/____ Signature _____

	Current	Past
NEUROLOGICAL		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Trembling Hand	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Speech	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
ENDOCRINE		
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
IMMUNIZATION/VACCINATION		
DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD TYPE

A+ A-
 B+ B-
 AB+ AB-
 O+ O-
 Other _____

BLOOD TRANSFUSIONS

Date ___/___/___
 Date ___/___/___
 Date ___/___/___
 Date ___/___/___

	Current	Past
PSYCHIATRIC		
Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Troubled Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Undecidedness	<input type="checkbox"/>	<input type="checkbox"/>
Timid	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

	Current	Past
MUSCLESKELETAL		
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICAL HISTORY

Please check only symptoms you have had in the past:

Hay Fever	<input type="checkbox"/>	Parasites	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Angina	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Gout	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	Prostrate Problems	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	Kidney Infections	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Dysentery	<input type="checkbox"/>

Date of last Chest X-Ray ___/___/___ Normal Abnormal

Last TB Skin Test ___/___/___ Normal Abnormal

Allergies: _____



CHIROPRACTIC ASSOCIATES OF MICHIGAN / 31850 Schoenherr / Warren, MI 48088 / Ph. 586.293.4440 / Fax 586.293.0840
<http://www.chirowarren.com/>
 A non-partnership of independent practitioners

PATIENT HISTORY

Patient Name _____ Date _____ Signature _____

FAMILY HISTORY: List any diseases on the REVIEW OF SYMPTOMS form, which run in your family.

	Age at Death	Age if Living	Cause of Death	State of Health	Illnesses
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Fraternal Grandmother	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Fraternal Grandfather	_____	_____	_____	_____	_____

SOCIAL HISTORY

Current Weight ____ Have you recently lost or gained weight? No Yes How much? _____

Mental Work: Heavy Moderate Light Hours per day ____ Physical Work: Heavy Moderate Light Hours per day ____

Exercise: Heavy Moderate Light Hours per day ____ Days per week ____ Type _____

Smoking: Currently smoke Smoked in past Packs per Day ____ # of years ____

Alcohol: Beers per Week ____ Liquor per Week ____ Wine per week ____ # of years ____

Caffeine (coffee, tea, cola): Cups per day ____ # of years ____

Aspirin: # per day ____ # of years ____ Others: _____

CONTACT INFORMATION

Date _____

Patient name (please print) _____

E-mail address _____

Please list any phone numbers that we have permission to use to confirm your appointments,
Put a check mark next to the phone number to call first.

Home (____) _____

Work (____) _____

Cell (____) _____

Other (____) _____

I realize that reminder calls are done as a courtesy. Ultimately, it is my responsibility to know my appointment date and time. I am aware that any missed appointments could result in an office visit charge.

Signature _____

Date _____

EMERGENCY CONTACT INFORMATION

Please give an emergency contact. Put a check mark next to the phone number to call first.

Contact name _____ Relationship _____

Home (____) _____

Work (____) _____

Cell (____) _____

Primary Care Physician: Name _____ Phone (____) _____

Address _____

City _____ State _____ Zip _____

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088

<http://www.chirowarren.com/>

A non-partnership of independent practitioners



586 / 293 - 4440 • Fax 586 / 293 - 0840

MISSED APPOINTMENTS POLICY

We ask for your assistance and cooperation in keeping your scheduled appointment date and time.

It is our policy that if a patient misses or cancels an appointment with less than 24 hours notice, that patient will be charged the regular office visit fee for that time. This policy is necessary to avoid the numerous schedule problems that last minute cancellations and missed appointments create!

If the need arises to cancel or change your appointment, we would appreciate 48 hours notice, when possible, but no less than 24, to avoid an unnecessary charge to you.

We thank you for your cooperation and look forward to being a vital part of your health recovery and maintenance.

I have read and understand the above policy:

Patient Signature

Date

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
<http://www.chirowarren.com/>

A non-partnership of independent practitioners



586 / 293 - 4440 • Fax 586 / 293 - 0840

HIPAA: CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that the Chiropractic Associates of Michigan Notice of Privacy Practices has been provided to me.

I understand my right to review the Chiropractic Associates of Michigan (CAM) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of CAM. This Notice of Privacy Practices also describes my rights and CAM duties with respect to my protected health information. The Notice of Privacy Practices for CAM can be provided, on request, at the front desk.

Chiropractic Associates of Michigan reserves the right to change the privacy practices described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed, or by asking for a copy at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that CAM has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge receipt of a copy of this notice, and my understanding, and agreement, to the terms:

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
<http://www.chirowarren.com/>

A non-partnership of independent practitioners



586 / 293 - 4440 • Fax 586 / 293 - 0840

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. I authorize you to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.
2. I authorize my attorney to make direct payments to you of any sum I now, or hereafter, owe. Payment is to be taken out of the proceeds of any settlement of my case and by any insurance company obligated to make payment to myself or you based, in whole or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to myself, or to you, for the charges for chiropractic services, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the pertinent data below) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that I am responsible for paying whatever amounts not collected from insurance proceeds (whether it be all or part of what is due).

INSURANCE PAYMENT AGREEMENT

Dear Patient,

Discrepancies can occur between information provided to us by your insurance company and what your insurance actually covers. Due to the unpredictable nature of insurance billing, it is possible that your insurance company may raise payment questions regarding coverage of payment.

YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED.

Most insurance companies provide literature outlining the specifics of their coverage. Please refer to this literature, or contact your insurance company directly, to answer any questions regarding your chiropractic health care coverage.

I have read and understand all of the above:

Patient Signature

Date

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
<http://www.chirowarren.com/>

A non-partnership of independent practitioners

586 / 293 - 4440 • Fax 586 / 293 - 0840

