

**ARTHRITIS & OSTEOPOROSIS CENTER OF KY
789 EASTERN BY-PASS, SUITE # 17
RICHMOND, KY 40475**

Patient Information:

Last Name: _____ First Name: _____ Middle Initials: _____

Date of Birth: ____/____/____ Sex: M / F

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: (____) _____ - _____
Work: (____) _____ - _____
Cell: (____) _____ - _____

Employer: Name: _____
Address: _____
Telephone: (____) _____ - _____

Spouse Information:

Name: _____

Date Of Birth: _____

Employer: _____

City: _____: State: _____

Telephone: (____) _____ - _____

Emergency Contact Information:

Name: (1): _____ Tel: (____) _____ - _____

(2): _____ Tel: (____) _____ - _____

Who may we discuss your health information with:

Only Myself: **Y** **N**: Spouse: **Y**. **N**. Others: **Y**. **N**. Name: _____

MEDICARE PATIENTS ONLY (Required by Medicare Program)

Are you or your spouse covered by an Employer Group Health Benefit Plan? **Y N**

Do you receive Black Lung Benefits? **Y N**

Do you receive workers comp benefits? **Y N**

Are you being seen for an injury or illness for which another party could be held liable or is covered under Automobile No fault insurance? **Y N**

CONSENT:

I hereby consent to Arthritis and Osteoporosis Center of KY using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Practice using or disclosing my protected health information for treatment activities provided by another health care provider; as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals. Specific Records Expressly Included, I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information.

INSURANCE CLAIMS:

We participate with numerous insurance plans and will gladly file your claims for you. **Co-Payments are due on the day of service.** This is generally required by your insurance plan as part of our contract with them.

INSURANCE PLANS REQUIRING REFERRALS:

Please check with your insurance plan to see if a referral or pre-authorization is required from your primary care doctor to see a specialist. It is your responsibility to obtain the necessary referral in order for your insurance company to pay for your services. We will be happy to assist you in obtaining your required referral.

ADULT STUDENTS COVERED BY PARENTS'S INSURANCE PLAN:

We will gladly file your claims however if you are over the age of 18, you are responsible for your bill. We will need your current address and your payment billing address for our records.

PATIENTS WITHOUT INSURANCE COVERAGE:

Unless prior arrangements have been made, payment in full is due on the day of service. We do not charge interest on unpaid balances; therefore, we cannot extend credit for more than 90 days.

RETURNED CHECKS:

We charge a \$30.00 processing fees for all returned checks due to bank processing fees. Any returned check must be pain within 10 days or it may be turned to a collections agency.

PRIVACY:

I have been offered and / or received a copy of Arthritis & Osteoporosis Center of Kentucky's Notice of Privacy Practices.

AUTHORIZATION:

I hereby give my permission to Arthritis & Osteoporosis Center of Kentucky for the evaluation and treatment of the presented rheumatologic condition. I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance. I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign all payments for medical services rendered. I have read the financial consent and privacy policy statements for Arthritis & Osteoporosis Center of Kentucky on the reverse of this page and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

Patient or Responsible Party:

Date:

Arthritis and Osteoporosis Center of KY

789 Eastern By-Pass, Suite #17 Richmond, KY 40475

Phone : (859) 623-5500 Toll Free: 1-888-422-6360

Fax: (859) 625-5007

New Patient Consultation Request

Referring Physician: _____ Date: ____/____/____
Phone# (____) ____-_____
UPIN# _____
NPI# _____ Tax Code# _____

Patient Name: First _____ .M__ Last _____
DOB: ____/____/____. SSN: ____-____-_____
Address: _____ City: _____
State: ____ Zip: _____
Home Phone# (____) ____-_____
Cell#(____) ____-_____ Work# (____) ____-_____

Primary Insurance: _____ Secondary Insurance: _____

Diagnosis/Symptoms: _____

**** Attach the most recent medical records including office notes, labs and x-ray reports. The patient should also bring any related x-ray films with them to their first appointment. ****

We will not be able to move forward with scheduling your patient without this necessary information. If you have not received an appointment date and time within 5-7 business days, please contact us at 859-623-5500.

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, or exempt from federal disclosure under applicable federal or state law. If the reader of this message is not the intended recipient, the employee or agent responsible for delivering the message, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you receive this communication in error, please notify us at 859-623-5500 immediately. We will provide you the consultation note after the patient has been seen at our office. Thank you for your kind referral.

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In the event your Insurance Carrier denies for not having a Referring Physician to our office, you, the patient, will be responsible for any payments not paid by your insurance company. This office will also do all we can in filing your secondary insurance (if any), but the patient will be responsible for payment if the secondary insurance carrier is a supplemental insurance, or other, that may not be credentialed with our office. We apologize for any inconvenience this may cause.

Signature of Patient

Date

ARTHRITIS & OSTEOPOROSIS CENTER OF KY
789 EASTERN BYPASS
BLDG. #1 STE #17
RICHMOND, KY 40475
PHONE: (859) 623-5500 / 1-888-422-6360
FAX: (859) 625-5007

AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

Name of Patient: _____

Address: _____

Date of Birth: _____

I hereby authorize _____ to furnish information related to my hospitalization/or treatment during the period of _____.

Signature of Patient

Signature and relationship of next of kin if patient is a minor or mentally incompetent.

ARTHRITIS & OSTEOPOROSIS CENTER OF KY

NOTICE OF PRIVACY PRACTICES

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care service. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices calling the offices and requesting that revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with a third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance to the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation *[This section will only be applicable to larger practices or those practices that operate facilities]*

Others Involved In Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death.

Finally, we may disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosure to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, or inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defect or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (*PHI*). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="radio"/> Home Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only
<input type="checkbox"/> O.K. to fax to this Number | <input type="radio"/> Written Communication
<input type="checkbox"/> O.K. to mail to my Home address
<input type="checkbox"/> O.K. to mail to my Work/Office address |
|--|--|

- | | |
|---|---|
| <input type="radio"/> Work Telephone _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="radio"/> Other _____

_____ |
|---|---|

_____ Patient Signature	_____ Date
_____ Print Name	_____ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosure of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is Authorized
 (2) Type Key: T=Treatment Records: P=Payment Information: O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax: P=Phone: M=Mail: O=Other

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www.arthritisky.com

****PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT****

*****PLEASE BRING A LIST OF YOUR MEDICATIONS*****

Name: _____ D.O.B. _____ Age: _____ Marital Status: _____

Address: _____

Family Physician: _____

Referring Physician: _____

Briefly describe your present symptoms and diagnosis, if known:

Current or Past Medical conditions other than described above: (Past Medical History)

Surgeries OR Operations in the past: (Past Surgical History)

Current Medications:

- | | | |
|-----|-----|------|
| 1.) | 5.) | 9.) |
| 2.) | 6.) | 10.) |
| 3.) | 7.) | 11.) |
| 4.) | 8.) | 12.) |

Allergies: _____

Personal History: Occupation: _____

Smoking History: _____

Alcohol Use: _____

Please encircle if you currently have or in the past had any of the following:

Diagnosed or Treated for:

- | | |
|--|--|
| <ul style="list-style-type: none">• Sexually Transmitted Diseases• Hepatitis• HIV• Tuberculosis | <ul style="list-style-type: none">• Any kind of cancer• Thyroid Disease• Diabetes• Blood clots• Anemia |
|--|--|

Pregnancy History:

- | | |
|--|---|
| <ul style="list-style-type: none">• # of Pregnancies _____• # of miscarriages _____ | <ul style="list-style-type: none">• # of live children _____• Family history of miscarriages |
|--|---|

Family History:

- Rheumatoid Arthritis
- Osteoarthritis
- Psoriasis
- Other _____
- Lupus (SLE)
- Autoimmune or Connective Tissue Disease

REVIEW OF SYSTEMS (Please check or encircle positive symptoms).**General:**

- Difficulty sleeping
- Loss of appetite
- Loss of weight
- Low energy level
- Fatigue

Mouth, Nose, Eyes and Ears:

- Dry mouth
- Mouth sores
- Nose sores
- Dry eyes
- Red eyes
- Eye pain
- Hoarseness of voice
- Pain in jaws or tongue while chewing food

Skin:

- Rash
- Skin ulcers
- Skin tightening
- Hair loss
- Lumps or knots under the skin
- Color changes in hands and feet with cold

Heart and Lungs:

- Chest pains
- Shortness of breath
- Swollen legs
- Cough
- Blood in sputum
- Wheezing

Gastrointestinal:

- Nausea/Vomiting
- Stomach pains
- Diarrhea
- Blood in stool
- Difficulty swallowing food
- Constipation

Nervous System:

- Headache
- Loss of vision
- Memory loss
- Numbness of arms or legs
- Urine or stool incontinence
- Weakness of arms or legs

Kidney and Genitalia:

- Urinary infections
- Kidney stones
- Vaginal or Penile discharges
- Rash on genitalia
- Pain or burning urinating
- Blood in urine

Endocrine:

- Cold intolerance
- Heat intolerance
- Excessive thirst
- Passing excessive urine

Allergic and Immunologic:

- Seasonal allergies
- Sinusitis

Muscles and Joints:

- Muscle pain
- Muscle stiffness
- Muscle weakness
- Morning stiffness
- Joint pain
- Joint swelling

Psychiatric:

- Mood swings
- Depression

Physician Initials with date: