

**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: