

Arthritis Center of Lexington • 330 Waller Avenue, Suite 100 • Lexington, KY 40504

PATIENT INFORMATION

Patient's Last Name	First	MI	Sex M F	Birth Date	Social Security #	Home Phone # ()
Mailing Address			City, State, and Zip		Cell Phone #	
Patient's Employer (If Applicable) Business Phone ()			Spouse/Parent(s) Name		Spouse's Birth Date	
Spouse's Employer (Include City and State)					Business Phone ()	
In Case of Emergency Contact:			Relationship		Phone # ()	
Who May We Discuss Your Health Information With? No One Other Than Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other – Name _____ May we leave messages regarding your health information on your voicemail/answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No						

MEDICARE PATIENTS ONLY (Required by Medicare Program)	
Are you or your spouse covered by an Employer Group Health Benefit Plan?	_____ YES _____ NO
Are you or our spouse working for an employer with more than 20 employees?	_____ YES _____ NO
Do you receive Black Lung Benefits?	_____ YES _____ NO
Do you receive workers comp benefits?	_____ YES _____ NO
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?	_____ YES _____ NO

Referred by: _____	PCP: _____
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INSURANCE INFORMATION - PLEASE PRESENT CARD TO RECEPTIONIST

CONSENT

I hereby consent to Arthritis Center of Lexington (the "Practice") 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. (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

<p>CHECK ANY OR ALL YOU AGREE TO AUTHROIZE FOR RELEASE:</p> <p><input type="checkbox"/> Chemical Dependency / Substance Abuse</p> <p align="center">○ Drugs ○ Alcohol</p> <p><input type="checkbox"/> Sexually Transmitted Diseases</p>

FINANCIAL

Our main goal is providing you the best care and service. We also recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our practice, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our patient accounts department.

PATIENTS WITHOUT INSURANCE COVERAGE

Unless prior arrangements have been made with the Patients Accounts Manager, payment in full" is due on the day of service. For your convenience, we accept cash, checks, Visa and MasterCard." We do not charge interest on unpaid balances; therefore, we cannot extend credit for more than 90 days. This provides you with sufficient time to secure outside financing through a lending institution such as a bank or finance company in order to make extended payments to fit your personal budget.

RETURNED CHECKS

Due to the expense of processing checks returned by the bank, we charge a \$25.00 service fee. Any returned check must be paid within ten (10) days or it may be turned over to a collection agency or the County Attorney's Office.

INSURANCE CLAIMS:

We participate with numerous insurance plans and will gladly file your claim 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. For insurance plans with whom we are not a contracted provider, we will gladly file your claim for you. Benefits will be assigned to us which means payment will be made directly to our office. A \$10 billing fee will be applied to your account if your co-pay is not paid at the time of service.

INSURANCE PLANS REQUIRING REFERRALS:

Please check your insurance plan to see if a referral or pre-authorization is necessary from your primary care doctor to see our specialists. 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 any way possible to obtain your required referral. If you arrive for your appointment without the required referral, you will need to reschedule the appointment when a referral can be secured.

ADULT STUDENTS COVERED BY PARENTS INSURANCE:

We will gladly file your claim for you. However, if you are over the age of 18, you are responsible for your bill. All co-payments are due on the day of service. We will need your current address and your permanent billing address for our files.

MINORS:

A parent or legal guardian must accompany all children under the age of 18. In the case of divorced parents, the parent bringing the child in for service is responsible for the bill.

PRIVACY:

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

AUTHORIZATIONS:

I hereby give my permission to Arthritis Center of Lexington for the evaluation and treatment of the presented rheumatological 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 Center of Lexington 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

Name _____ Date of Birth _____
 Address _____ Apt _____ Phone (____) _____
 City _____ State _____ Zip _____

Primary reason you are seeing Dr. Goldfarb: _____

Doctor who referred you here: _____

Primary Care Doctor: _____

Current Medications (Name of Drug, strength, how often taken): _____

Medication Allergies: _____

Other Medical Problems? (List): _____

What operations have you had? (List type of operation and date): _____

Female patients -- # of Pregnancies: _____ # of Live Births: _____ # of Pregnancies Lost: _____

of Children Living: _____ Date of last period started: _____

Date of Last Pap: _____ Date of Last Mammogram: _____

How much calcium do you take? _____ Have you ever taken female hormones? _____

Family Illnesses (Grandparents, Parents, Aunts, Uncles, Brothers, Sisters, Children): _____

Social History -- Married ___ Single ___ Divorced ___ Widowed ___

Do you now or have you ever smoked? _____ How much? _____ How Long? _____

Do you drink alcohol? _____ How much a week or month? _____ How long? _____

How many years of school did you attend? _____ Are you currently working? _____

At what job? _____

Do you drink coffee or caffeinated drinks? _____ How many a day? _____

How many people are in your household? _____

Please put a check by any of the following symptoms which you have had in the last six months:

Fever _____

Stiff Neck _____

Blood in Urine _____

Chills _____

Chest Pain _____

Sexual Problems _____

Night Sweats _____

Cough _____

Difficulty Tolerating the Sun _____

Loss of Appetite _____

Shortness of Breath _____

Fingers Turn Color in the Cold _____

Weight Loss _____

Heartburn _____

Rash _____

Weight Gain _____

Nausea _____

Problems with Thinking or

Fatigue _____

V omitting _____

Loss of Memory _____

Headache _____

Difficulty Swallowing _____

Trouble Sleeping _____

Dizziness _____

Diarrhea _____

Tremors _____

Loss of Vision _____

Constipation _____

Difficulty Walking _____

Double Vision _____

Blood in Stool _____

Numbness _____

Dry Eyes _____

Stomach Cramping _____

Weakness _____

Red Eyes _____

Painful Urination _____

Anxiety _____

Change in Hearing _____

Frequent Urination _____

Depression _____

Nose Bleeds _____

Nighttime Urination _____

Anemia _____

Sores in Mouth _____

Difficulty Passing Urine _____

Easy Bruising _____

Dry Mouth _____
