

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 10 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

Arthritis Center of Lexington

Kelly Cole, M.D. • Rita Egan, M.D. • Jeffrey Neal, M.D. • Paul Goldfarb, M.D.

330 Waller Avenue, Suite 100
Lexington, Kentucky 40504
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Phone: (859) 254-7000 - Fax: (859) 255-4381

Name _____ Date _____

Please answer the following questions.

1. How is your energy? _____
2. Have you had any weight change in the past 12 months? _____
3. How is your appetite? _____

Please put a check mark beside each of the below which you have frequently or repeatedly.

Headaches	_____	Hair Loss	_____
Recurrent rashes	_____	Skin nodules	_____
Rash with sun exposure	_____	Psoriasis	_____
Blurred vision	_____	Double vision	_____
Dry eyes	_____	Red, painful eyes	_____
Iritis	_____	Conjunctivitis	_____
Ringling of ears	_____	Hearing loss	_____
Sinus infections	_____	Environmental allergies	_____
Sores in the nose or mouth	_____	Dry mouth	_____
Severe dental problems	_____	Excessive thirst	_____
Excessive urination	_____	Inability to tolerate heat	_____
Inability to tolerate cold	_____	Chronic cough	_____
Coughing blood	_____	Shortness of breath	_____
History of tuberculosis (TB)	_____	Pleurisy	_____
Chest pain	_____	Heart skipping a beat	_____
History of rheumatic fever	_____	Hands changing color with cold exposure	_____
Constipation	_____	Black, tarry bowel movements	_____
Diarrhea	_____	Vomiting	_____
Blood in stools	_____	Hepatitis or yellow jaundice	_____
Gallbladder problems	_____	Blood in your urine	_____
Burning in urination	_____	Seizures	_____
Kidney stones	_____		
Loss of consciousness	_____		
Weakness or numbness in arms and legs	_____		

PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT

Name: _____ Age: _____

Referring Physician: _____ Address: _____

Reason You Are Here: _____

Past Medical History:

1. List All Surgeries And The Year They Were Done:

2. Do You Have Any Of The Following?:

- Diabetes _____
- Thyroid Disease _____
- Lung Disease _____
- Ulcers _____
- Any Form of Cancer _____
- Blood Problems
(Such as Leukemia, Anemia) _____
- Heart Disease _____
- Heart Attack _____
- High Blood Pressure _____
- Kidney Disease _____

Any Other Medical Illnesses Not Mentioned? _____

3. Have you Ever Had A Blood Transfusion:

If So, When? _____

4. Females: Have You Been Pregnant? _____

How many Times? _____

If any Miscarriages, At What Point In The Pregnancy? _____

5. List All Medications You Are Taking And Their Doses: _____

6. Are You Allergic To Any Medications?

If So, List and Describe Type of Reaction: _____

7. Any Major Injuries (Fractures, etc.)? _____

Family History: For Your Relatives Listed, Write in Age (Or Age At Death) And All Medical Illnesses and/or Cause of Death. Especially Important Are Arthritis, Cancer, High Blood Pressure, Diabetes, Heart Disease, Lupus, and Lung Disease, But Not Limited To These Diagnoses:

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Children: _____

Do Any Other Diseases Tend To Occur In Your Family? (Please List and Write Relatives With The Disease):

Social History:

1. Are You Married? _____

Divorced? _____

Widowed? _____

2. What Type of Work Do You Do or Have You Done? _____

3. Where Do You Live? _____

Who Lives With You? _____

4. Do You Have Pets? _____

What Type? _____

5. Do You Smoke? _____

How Many Packs A Day? _____

For How Long? _____

6. Do You Drink Alcohol? _____