

<b>PATIENT INFORMATION</b> <i>*PLEASE SIGN AND DATE REVERSE SIDE</i>			Email _____			
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)		Spouse's Social Security # <i>(if insurance provider)</i>			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						
Referred by: _____				Family Care: _____		

Please complete the following as required in accordance with the demographics stands §170.207(f) asking a patient to specify race, language, and/or ethnicity. Please check the most appropriate answer.

**RACE:**   ☐ White   ☐ American Indian/Alaskan Native   ☐ Asian   ☐ Black or African American   ☐ Multiracial  
                   ☐ Native Hawaiian or Pacific Islander   ☐ Other Race   ☐ Decline

**LANGUAGE:**   ☐ English   ☐ Spanish   ☐ Other   ☐ Unknown/Not Reported   ☐ Decline to specify

**ETHNICITY:**   ☐ Hispanic or Latino   ☐ Not Hispanic or Latino   ☐ Unknown   ☐ Decline to specify

<b>MEDICARE PATIENTS ONLY (Required by Medicare Program)</b>	
Are you or your spouse covered by an Employer Group Health Benefit Plan?	____ YES    ____ NO
Are you or your 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	

**INSURANCE INFORMATION – PLEASE PRESENT CARD TO RECEPTIONIST**

<b>CONSENT</b>
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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.

I hereby consent if at any time I provide a wireless telephone number at which I may be contacted, I may receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the office to the contrary in writing. Calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collecting agencies.

I hereby consent if at any time I provide an email address at which I may be contacted, unless I notify the office in writing, I may receive instructions, statements, bill, marketing material for new services and payment receipts at that email address from the office.

**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):

<b>CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE:</b>
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- |  |                             |                               |
|--|-----------------------------|-------------------------------|
| <input type="checkbox"/> Chemical Dependency/Substance Abuse | <input type="radio"/> Drugs | <input type="radio"/> Alcohol |
| <input type="checkbox"/> Sexually Transmitted Diseases       |                             |                               |

**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.

**NO SHOW POLICY**

Our office policy provides a courtesy call to all of our established patients prior to your scheduled appointment. You may receive an automated call so please listen to the entire message and respond as requested. If you are unable to keep an appointment, we request that you call our office at least 24 hours in advance so we may utilize the space to care for other patients. Therefore, patients who do not choose to call our office within 24 hours to cancel their appointment, will be charged a \$25 no-show fee and may be dismissed from the practice on the third occasion.

**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 \$25.00 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

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