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

**PATIENT INFORMATION**

**PLEASE SIGN AND DATE REVERSE SIDE*

| 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 Social Security # (If insurance subscriber) | Race, Ethnicity, Language | | | |
| In Case of Emergency Contact: | Relationship | Phone # ( ) | | |

Who May We Discuss Your Health Information With?
No One Other Than Self ❑ Spouse ❑ Parent ❑ Other - Name _____
May we leave messages regarding your health information on your voicemail/answering machine? ❑ Yes ❑ No

Referred by: _____ PCP: _____

**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 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**

**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):

**CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE:**

❑ Chemical Dependency/Substance Abuse

○ Drugs ○ Alcohol

❑ 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 $35.00 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**