PATIENT REGISTRATION

TRISTATE ARTHRITIS & RHEUMATOLOGY

Kerrin D. Burte MD: ___ Joseph E. Temming, M.D. ___ Liza R. Varghese, M.D. ___ C. Lee Colglazier MD: ___

Malini Juyal, M.D. ___ Drew M. Huffman DO: ___ M. Blair Whitaker PA: ___

PATIENT INFORMATION: (PLEASE PRINT)

NAME: _____ **BIRTHDATE:** _____ **SS#:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: (___)_____ **WORK PHONE:** (___)_____ **CELL PHONE:** (___)_____

SEX: M___F___ AGE: ___ **MARITAL STATUS: SINGLE___MARRIED____DIVORCED____WIDOWED_____**

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

INSURANCE INFORMATION

(IF YOU WANT YOUR INSURANCE SUBMITTED BY OUR OFFICE, PLEASE FILL OUT THIS ENTIRE SECTION)

	PRIMARY INSURANCE	SECONDARY INSURANCE
NAME INSURANCE CO.....1)	_____	2)_____
ADDRESS.....1)	_____	2)_____
	_____	_____
SUBSRIBER'S ID#.....1)	_____	2)_____
SUBSCRIBER'S GROUP#.....1)	_____	2)_____
SUBSCRIBER'S NAME.....1)	_____	2)_____
SUBSCRIBER'S SS#.....1)	_____	2)_____
SUBSCRIBER'S D.O.B.....1)	_____	2)_____
SEX.....M____F_____		**SEX.....M____F_____**
PATIENT RELATIONSHIP.....1)SELF___SPOUSE___CHILD___		**2)SELF___SPOUSE___CHILD_____**

REFERRING DR NAME _____ FAMILY DR_____

ADDRESS_____ ADDRESS _____

PHONE NUMBER_____ PHONE NUMBER_____

RELEASE OF PROTECTED HEALTH INFO. AND PAYMENT FOR SERVICES: I authorize the use and disclosure of protected health info. and other demographic info. to carry out treatment, payment and health care operations. Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures. I authorize the assignment and payment of my insurance benefits to the physicians of Tristate Arthritis & Rheumatology, MD to include government services. If my insurance plan does not cover the medical services or does not pay for certain services or does not pay for certain services or good as benefits, I agree that I am financially responsible. Also, I understand that I AM RESPONSIBLE FOR ANY REFERRALS REQUIRED BY MY INSURANCE COMPANY, ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY BALANCE NOT PAID FOR BY MY INSURANCE.

How did you hear about us?

***Referred by doctor** ***Referred by Family/Friend** ***Website** ***Other??**_____

_____

SIGNATURE **DATE**

NAME: _____

LIST ALL <u>ALLERGIES</u> TO MEDICATIONS:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

LIST ALL CURRENT MEDICATIONS:

NAME/DOSE/HOW OFTEN	NAME/DOSE/HOW OFTEN	NAME/DOSE/HOW OFTEN
1.	8.	15.
2.	9.	16.
3.	10.	17.
4.	11.	18.
5.	12.	19.
6.	13.	20.
7.	14.	21.

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING (please circle all that apply)

Alcoholism	Lung Disease	Anorexia	Lupus	Asthma
Osteoarthritis	Blood Clots	Osteoporosis	Cancer	Psoriasis
Diabetes	Scleroderma	Depression	Gout	Rheumatoid Arthritis
Stroke	Hay Fever	TIA	Hepatitis	Thyroid Problems
Tuberculosis	Ulcers	Kidney Disease	Liver Disease	Hypertension (high blood pressure)
Drug Abuse	Irritable Bowel/Colitis	Heart Disease/Heart Attack		

Smoking (How Long _____)

DOES ANY MEMBER OF YOUR FAMILY HAVE A HISTORY OF ANY (please circle all that apply)

Cancer	Osteoarthritis	Depression	Diabetes	Psoriasis
Gout	Lupus	Scleroderma	Rheumatoid Arthritis	Heart Disease/Heart Attack

PREVIOUS SURGERIES

_____

_____

PLEASE EXPLAIN IN DETAIL WHAT YOU ARE BEING SEEN FOR TODAY

_____

_____

TRISTATE ARTHRITIS AND RHEUMATOLOGY
AND ITS AFFILIATED COVERED ENTITIES
ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Tristate's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by calling 859-331-3100, by visiting Tristate's website at www.tristatearthritis.com or by requesting one at Tristate.

SIGNATURE:_____ **DATE:**_____

I authorize the office of Tristate Arthritis & Rheumatology to discuss my medical information, i.e., diagnosis, lab results and test results, with the following people listed below:

Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**
Name	**Relationship**	**Phone Number**

If you are not the patient, please fill out the following information:

Name:_____

Relationship to Patient:_____

Address:_____

Telephone:_____

Please furnish a copy of any conservator/guardianship papers with this form.

Tristate Arthritis & RHEUMATOLOGY
Quality Compassionate Care

OFFICE FINANCIAL POLICY

Thank you for choosing Tristate Arthritis and Rheumatology as your health care provider. We are committed to your treatment being successful and we value your trust in us. It is our goal to partner with you to help you understand the billing process. In order to achieve this goal we ask that you read and sign this Financial Policy. Please understand that payment of your bill is part of the treatment process.

- We are happy to file your insurance claim for you. In order to work with your insurance carrier, we must have complete, correct, and current registration information, a photo ID, a copy of your current insurance card, and your signature on file. **Please bring your current health insurance card with you to every visit.** We will ask to see it every time to ensure we are sending your medical bills to the right insurer and to check for your eligible coverage benefits.
- If you have more than one insurance coverage, please check with your insurance carriers to determine which policy is primary and which is secondary. **This is not the choice of the member and is only determined by the insurance carriers.**
- Please inform us of any and all changes to your insurance information and/or your address, phone number, etc. We need this information to be current in order to correctly file your insurance claim. You are responsible for any charges that are denied by your insurance carrier which result from incomplete and/or out-of-date coverage information.
- Patients who are self-pay or have no insurance will be required to pay all charges **in full** at the time of service. Future appointments cannot be scheduled until the balance is paid in full.
- **Your co-pay is due at the time of service**. Your health insurance benefits and our contract with your insurer require we collect these co-pays and we will be requesting this payment at the time of your visit. A $10 processing fee will be added for any co-pay not paid at the time of service. Additionally, you will not be able to schedule any future appointments with our practice until your co-pay is paid plus any additional fees.
- Payment for any outstanding balances that you may owe on your account may also be requested at the time of your visit. Please note your visit may be rescheduled if this balance is not paid. We accept cash, checks, MasterCard, Visa, Discover, and American Express. (Any returned check is subject to an additional $25 fee).
- There may be charges that your insurance carrier considers "non-covered", "out-of-network", or "out-of-pocket". You are responsible for these charges and authorize Tristate Arthritis to bill you for any appropriate services. This is in accordance with your insurance carrier contract.
- We do understand special financial circumstances and offer payment plans if you are unable to pay for the cost of your health care at the time of billing. For most of our payment plans, we ask that account balances be paid in full within 3 consecutive monthly payments.
- Account balances are due in full within 30 days of receiving our statement unless other arrangements have been made. If your balance goes over 90 days past due and you have not contacted our billing department to make payment arrangements, we will turn your account over to a collection agency. If this occurs, you agree to assume responsibility for all additional fees and services charged by the collection agency. **Additionally, you will not be able to schedule future appointments with our practice until the collection account is paid in full.**

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE FINANCIAL POLICY

Print Name_____ Date_____

Signature_____

2018/11

Updated as of June 2018

Tristate Arthritis and Rheumatology
Controlled Substance Prescription Policy and Consent
Updated to be in compliance of Kentucky House Bill 1, 2012

The following policy applies to the prescribing of controlled substances.

-All patients receiving controlled substance medication must sign a controlled substance consent form.

-The use of any controlled substance involves a risk including but not limited to tolerance, dependence, and addition. A controlled substance should only be obtained after a careful discussion of the risks and benefits with the prescribing physician. Although it might be determined that the benefits outweigh the risks, it is understood that any dose or frequency of any type of controlled substance still involves a risk of addiction.

-The use of any controlled substance can cause an alternation of mental status, including but not limited to drowsiness, confusion, lightheadedness, and slowed reflexes, which can increase the risk of falls and decreased performance. Patients receiving a controlled substance agree to refrain from any activity, such as operating a motor vehicle, which can put themselves or others at risk. The use of other mental status altering medications or substances (such as alcohol) in combination can increase the overall risk of complications and should be avoided.

-Initial controlled substance prescriptions cannot be given without a face-to-face visit.

-Prescriptions cannot be refilled without a face-to-face physician visit at minimum every three months, at which time the physician is required by law to query the Kentucky All Schedules Prescription Electronic Reporting (KASPER) System.

-It is the responsibility of the patient to schedule routine follow-up appointments in advance for refills. Failure to schedule an appointment, or cancelling an appointment, does not constitute an emergency appointment for refills.

-At the time of the visit, a patient will be given enough medication to last until the next physician visit or nurse refill visit. **IF A PATIENT FEELS THE MEDICATION REGIMEN IS INADEQUATE, OR HAS A SIDE EFFECT, THE ISSUE MUST BE ADDRESSED IN PERSON DURING A FACE-TO-FACE VISIT. NO CHANGES TO THE REGIMEN WILL BE MADE OVER THE PHONE. IF A PATIENT ALTERS THE PRESCRIBED REGIMEN WITHOUT PHYSICIAN INSTRUCTION AND RUNS OUT EARLY, NO EARLY REFILLS OR ADDITIONAL MEDICATION WILL BE GIVEN, AND THE PATIENT WILL HAVE TO WAIT FOR AN APPOINTMENT FOR ANY ADDITIONAL INTERVENTION.**

-RUNNING OUT OF PAIN MEDICATION EARLY DUE TO INAPPROPRIATELY TAKING THE MEDICATION DOSE NOT CONSTITUTE AN EMERGENCY APPOINTMENT. If no appointments are available, a patient must either wait for an appointment or go to the emergency room.

-The patient is responsible for finding out what days and times the office is open. **NO CONTROLLED SUBSTANCES WILL BE PRESCRIBED WHEN THE OFFICE IS CLOSED BY THE ON CALL PHYSICIAN.**

-The patient is responsible for their medications and prescriptions at all times. **EARLY REFILLS AND REPLACEMENT PRESCRIPTIONS WILL NOT BE GIVEN FOR LOST, STOLEN, OR DAMAGED MEDICATIONS OR PRESCRIPTIONS.**

-Any complications, including the loss of a prescription, involving a mail order pharmacy is to be resolved by the patient and the mail order pharmacy. **WE ARE NOT RESPONSIBLE FOR THE LOSS OF A PRESCRIPTION BY THE MAIL, OR FOR THE LOSS OF A PRESCRIPTION BY THE MAIL ORDER PHARMACY.**

-All prescriptions for controlled substances should be filled at one pharmacy.

-Tristate Arthritis and Rheumatology will only prescribe controlled substances to patients who have not been diagnosed with, treated for, or arrested for substance abuse or addiction. Signing this agreement is an attestation that a patient has never been involved in the sale, illegal possession, dispersion, or transport of controlled substances, or been discharged by another physician for violating a controlled substance contract.

-Controlled substances are only to be taken unaltered by the patient to whom they have been prescribed following the prescribed directions. Medications cannot be given to others.

-Patients receiving controlled substances agree to allow physicians at this office to discus his or her care freely with other treating physicians, including sending a copy of office notes.

-Patients who are prescribed controlled substances by Tristate Arthritis and Rheumatology will not receive controlled substances by other physicians, except in cases of emergency in which case they will notify the office. Patients also allow the office to randomly check bodily fluids and pill counts as part of recommended screening protocols.

-Female patients treated with controlled substances including narcotic pain medication understand side effects to an unborn baby are possible and will certify they are not pregnant before taking controlled substances including narcotic pain medications.

-Tristate Arthritis and Rheumatology reserves the right to discontinue treatment with controlled substances if it is reasonably suspected that a patient has not been compliant with the controlled substance contract.

By signing below, I certify that I have read, understand, and agree to abide by the Tristate Arthritis and Rheumatology controlled substance prescription policy and consent.

_____
Patient Signature

_____
Printed Patient Name

_____
Date

_____
Witness