Patient Information Forms

Date: _____ **PLEASE PRINT LEGIBLY**

Name: _____
First Middle Last

Social Security Number: _____**Date of Birth**_____ **Age**_____

Home Phone _____**Work Phone** _____**Cell Phone**_____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email address:_____ **Employer:** _____

Work Address: _____

Occupation: _____**Work Phone Number** _____

Marital Status: Single Married Divorced Widowed **Spouse:**_____

Spouse's Employer: _____ **Spouse's Work Phone:**_____

Nearest Relative (not living with you)_____
Name Phone

Referring Physician:_____

Please briefly describe your present medical symptoms:

_____

_____

Family History

	IF LIVING			IF DECEASED	
	Sex	Age	State of health	Age at death	Cause of death
Father	**Male**				
Mother	**Female**				
Brothers/Sisters					
Spouse					
Children					

Forms reviewed by: _____ (healthcare provider initials) Date: _____

Please list any pertinent family history health conditions:

_____

_____

_____

_____

Personal History

Do you currently have any of the following health conditions?

Heart Attack _____ Age_____

High Blood Pressure _____

Congestive Heart Failure _____

Rheumatic Heart Disease _____

Congenital Heart Disease _____

Breast Cancer _____ Age_____

Colon Cancer _____ Age_____

Leukemia_____

Melanoma(Skin Cancer)_____

Ovarian Cancer_____

Pancreatic Cancer_____

Any other cancer _____

Asthma _____

Tuberculosis _____

Colitis _____

Crohn's Disease _____

Colon Polyps _____

Hepatitis_____

Stomach ulcer_____

Kidney Disease_____

Stroke_____

Migraine _____

Seizures _____

Diabetes _____

Goiter_____

Bleeding Tendency_____

Suicide _____

Mental Illness_____

Please list the names of any diseases you have had which required hospitalizations:

_____

_____

Please list any serious illnesses you have had which did NOT require hospitalization:

_____

_____

Serious injuries or accidents:

_____

_____

Write in the names and year of any operations you have had:

_____

_____

_____

Yes **No** Have you ever had a heart cath? When_____

Yes **No** Have you ever had stents placed? When_____

Yes **No** Have you ever had bypass surgery? When_____

Yes **No** Have you ever had a heart valve procedure or surgery? When_____

Yes **No** Have you ever been treated for atrial fibrillation or an irregular heart beat?
When_____

Yes **No** Have you ever had a colonoscopy? When_____ Where_____

Yes **No** Have you ever had an EGD? When_____ Where_____

Immunization History:

	Date of vaccination
Flu vaccine	_____
Pneumonia vaccine	_____
Tetanus	_____
Hepatitis B	_____
Shingles Vaccine	_____

Personal Habits

Please circle your response

Yes **No** Do you regularly smoke? Cigarettes ____ Pipe ____ Cigars _____

For how many years? _____ How many packs per day? _____

Yes **No** Have you regularly smoked in the past? When did you quit? _____

Yes **No** Have you ever used recreational drugs? When?_____

Yes **No** Do you regularly drink alcohol?
Beer: Number of bottles or cans per day _____
Wine: Number of glasses per day _____
Liquor: Number of ounces per day _____

Yes **No** Have you had 6 or more drinks of alcohol during a drinking session in the past year?

Yes **No** Do you awaken frequently at night?

Yes **No** Do you have more than one sex partner?

Yes **No** Has the person you live with hit you or hurt you physically in the past?

Yes **No** Has any person verbally abused you?

Please list medications you are currently taking:

Name	Dose	How often you are taking

Please list any drug allergies you have:

_____

Do you usually receive antibiotics before dental procedures? Yes No

Please list any other doctors that you see:

Name	Reason you see them

To be completed by **females** only.

Yes **No** Are you pregnant or could you be?

Yes **No** Have you had a hysterectomy? When? _____

Yes **No** Are you still have regular monthly periods? Date of last period _____

Yes **No** Have you ever had bleeding between your periods? When? _____

Yes **No** Do you feel bloated and irritable before your periods?

Yes **No** Have you ever had a discharge from the nipple? When? _____

Yes **No** Are you now or have you ever been on birth control pills? When? _____

Yes **No** Do you regularly have a PAP smear? Date of last test _____

Yes **No** Do you regularly have a mammogram? Date of last test _____

Last Bone Mineral Density test _____

How many children born alive? _____ How many miscarriages? _____

How many stillbirths? _____ How many Cesarean operations?_____

How many premature births?_____ Any complications of pregnancy? _____

****

Thank you for your patience and cooperation in completing these information forms. The information you have given will enable us to determine the medical treatment you may need.

MT. STERLING CLINIC, PLLC
100 Sterling Way, Suite 1
Mt. Sterling, KY 40353

WELCOME TO THE MT. STERLING CLINIC!

Our primary goal is to provide quality medical care to all patients. In order to provide the highest quality of care, we ask that all patients become familiar with our office policies which are as follows:

FINANCIAL POLICIES

YOU MUST BRING YOUR INSURANCE CARD(S) AND PHOTO ID WITH YOU TO EACH VISIT.

All copays MUST be paid at the time of service as per our contracts with insurance companies who require our office to collect your copay. Therefore, if you do not have your copay with you at the time of service, you may be asked to reschedule your appointment. Our office accepts check, cash or money orders. We do not accept credit or debit cards due for transactions under $50.00 due to the high cost of equipment and transaction fees.

Because it is the responsibility of the patient to provide correct insurance information, there will be a billing fee of $10.00 associated with any service that must be refiled to a different insurance due to failure of the patient to provide correct insurance information.

We allow 45 days for your insurance to make payment. If after 45 days, your insurance has not paid, the balance will become your responsibility. We will bill secondary insurance companies for balances over $10.00. We do not bill third insurances. Any balance remaining after your insurance payment is your responsibility and must be taken care of within 30 days of receipt of your billing statement from our office. Any account considered to be delinquent by our office will result in your account being placed with a collection agency for further action. A collection fee of $75.00 will be added to your account at that time. This information will become a part of your credit record.

REFILL POLICY

Please plan ahead when needing refills as our office requires 72 hour notice for all refill requests. All refill requests should be handled through your pharmacy. Please phone or visit your pharmacy 72 hours prior to needing your refill. Your pharmacy will contact our office for refill authorization. Please note that our office will not refill pain medications or antibiotics without seeing you in the office.

We do require patients to bring in ALL medications taken on a regular basis to EACH appointment.

If your insurance company requires that you use a mail order service for prescriptions, we will be glad to provide you with written prescriptions at the time of your visit. We do not routinely fax or mail prescriptions for mail order medications. It is your responsibility to see that your mail order company receives your prescriptions.

APPOINTMENT POLICY

We have multiple providers working in our office each day. Each provider has a separate schedule. This means that there may be more than one patient down at the same time but with a different provider. Patients are seen in the order of their scheduled appointment time for each provider.

We strive to accommodate all call-in requests for appointments within a 24 hour time period. In addition to our physicians on staff, our office also employs physician assistants and nurse practitioners. Our physicians have great confidence in our physician assistants and nurse practitioners. Should a physician not be available to see you, we will be glad to schedule an appointment for you with our physician assistant or nurse practitioner. Because we are a busy office, we do ask for a 24 hour notice if you are not able to keep your appointment. This enables us to schedule someone else who may need an appointment that day in the open spot. Failure to notify our office that you will not be keeping your scheduled appointment may result in a $30.00 billing fee for your missed appointment. Failure to keep three or more scheduled appointments without notification may result in dismissal from our practice.

MEDICAL RECORDS

Our office requires 72 hours notice for all request for medical records.

SHARING OF MEDICAL INFORMATION

Due to federal privacy laws, we cannot discuss your medical information with relatives or friends without your express written permission. If you have a power of attorney to handle your medical affairs, we must have a copy of that legal agreement for our files.

Please list below anyone you wish to have permission to discuss your medical care or medical information. This information will remain in our files unless permission is revoked in writing by the patient.

PERSONS PERMITTED TO RECEIVE INFORMATION REGARDING MY MEDICAL CARE OR CONDITION

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

This is to confirm that I have read and understood the policies of the Mt.Sterling Clinic as outlined above. I have also been given a copy of the Mt. Sterling Clinic Notice of Privacy Practices.

By signing below, I give consent to the physicians, mid-level providers, and nursing staff to provide my medical care until I terminate my relationship with the Mt. Sterling Clinic.

I REQUEST THAT PAYMENT OF ANY INSURANCE (INCLUDING MEDICARE) BENEFITS BE MADE TO THE MT. STERILNG CLINIC, PLLC ON MY BEHALF FOR ANY AND ALL SERVICES RENDERED BY THE MT. STERLING CLINIC, PLLC. I ALSO HEREBY AUTHORIZE THE MT. STERLING CLINIC, PLLC TO RELEASE ANY INFORMATION NECESSARY TO PROCESS SUCH CLAIMS.

SIGNATURE _____ **DATE** _____

Name of Patient _____ **Date of Birth:** _____

MT. STERLING CLINIC, PLLC
100 Sterling Way, Suite 1
Mt. Sterling, KY 40353
859-498-0200
www.mtsterlingclinic.com

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation

- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes

- Sale of your information

- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

The Mt. Sterling Clinic never markets or sells patient information.

This notice is effective 4-1-2015.

PRIVACY OFFICER:
Gail Creech may be contacted at 859-498-0200.