Kentucky Orthopedics & Sports Medicine

NEW PATIENT REGISTRATION PACKET

Today's Date _____ DOB: _____ Social Security # _____

Last Name: _____ First Name: _____ Previous/Nickname: _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Patients Race: ☐ American Indian or Alaska native ☐ Asian ☐ Native Hawaiian or other Pacific island
☐ Black or African American ☐ White ☐ Hispanic or Latin Other Race _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Street Address (If different from mailing address): _____

Patient's Primary Care Provider: _____ Referring Provider: _____

CONTACT INFORMATION

☐ Primary Phone #: _____ ☐ **Extended)** O.K. to leave message with detailed information
☐ **Brief)** Leave message with call-back number only

☐ Secondary Phone #: _____ ☐ **Extended)** O.K. to leave message with detailed information
☐ **Brief)** Leave message with call-back number only

☐ Email Address: _____ Primary Language: _____

EMERGENCY CONTACT INFO

Contact Name: _____ Relationship to Patient: _____

Primary Phone #: _____ Secondary Phone #: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Pharmacy Phone #: _____

Authorization and Consent to View RX History from External Source:

I authorize KOSM to view all available RX History from an external source. I am aware that KOSM uses a secure connection to send and receive prescriptions.

_____ _____ _____

(Signature of Patient, or Patient Representative) Date Relationship to Patient if not signed by Patient

Page 2: **Patient Name:** _____ **DOB:** _____

EMPLOYER INFORMATION

Employer Name: _____ Employer's Phone #: _____ Status FT PT

Is this a work related injury or motor vehicle accident? Yes or No If yes, please answer the following questions:

Date of Injury: _____ Claim#: _____ Case Manager: _____

PATIENT INSURANCE

Primary Insurance: _____ Secondary Insurance: _____

Cardholder (if not Patient): Name: _____ DOB _____ SSN# _____

PATIENT HAS PROVIDED KOSM WITH A COPY OF THEIR MOST UP-TO-DATE AND ACCURATE INSURANCE CARDS

Consent for Insurance Assignment/Payment:
I hereby authorize the assignment of benefits (payments) directly to KOSM for all my insurance claims related to services received. I agree to pay any and all charges that exceed or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____

(Authorization will remain in effect from date signed until revoked in writing by patient or patient representative)

ACKNOWLEDGED RECEIPT OF HIPAA NOTICE

KOSM is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the HIPAA Notice of Privacy Practices and Patient Bill of Rights. (Attached)

_____ _____
Patient or Legal Guardian Date

In accordance with the HIPAA guidelines, /KOSM is authorized to discuss my medical information with the following individuals.

HIPAA Authorized Person's Name	Relationship to patient	Phone Number

Do you utilize a transportation service? Yes ☐ No ☐

If yes, may KOSM give information regarding dates and times of appointments to this service? Yes ☐ No ☐

Do you have a medical Power of Attorney? Yes ☐ No ☐ (If so, please provide a copy for our records)

KOSM FINANCIAL POLICY

PLEASE READ THE FINANCIAL POLICY CAREFULLY BEFORE SIGNING

In keeping with our philosophy of open communication and education, it is important that you understand the financial policies of the practice. It is equally important that you understand the terms of YOUR OWN medical coverage. Your insurance policy is a contract between you and your insurance company. Although our staff is very knowledgeable of most insurance plans, it is important that you know the details and terms of your personal plan. Typically, you will find the insurance company's phone number on the back of your insurance card and we encourage you to contact them with questions specific to your coverage.

If your insurance plan requires a referral, you must contact your PCP prior to receiving care from us. **Regretfully, many insurers will not cover specialty services that are rendered without a referral and you may be held responsible for the costs.** Note: All ongoing referral renewals are the responsibility of the patient.

At each office visit, you will be asked to:

(1). Provide your most accurate and up-to-date insurance card (as well as any secondary or tertiary insurance info)
(2). Provide us with a copy of your current photo identification
(3). Verify your correct address and phone number
(4). Make payment of your co-pay by cash, check, debit, or credit card (Returned checks will be charged a $40.00 fee).

Your insurance company REQUIRES us to collect co-payments at the time services are rendered. Failure to collect your co-payment may constitute fraud under state and federal law. Please be prepared to pay your co-payment on the date services are rendered.

Our office requires a 24-hour notice to cancel an appointment. **A $50 fee may be assessed to patients that do not provide this required notification.**

If you are having a medical procedure, our staff will obtain a pre-certification prior to your visit. We encourage you to contact your insurance company prior to your procedure date to obtain an accurate amount of the co-insurance or other monies that may be due relative to the portion of the charge that is your financial responsibility.

KOSM participates in most major health plans and will submit claims for services. It is the patient's responsibility to provide all necessary information to file the claims prior to leaving our office. We will file your primary and secondary insurance claims and work diligently with the carrier to resolve any conflicts that may arise. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with this request.

You may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed to you. If genuine financial difficulties exist, please call our office. We are happy to work with you in resolving your balance and may be able to set up payment arrangements.

Any patient balances that remain delinquent after 90 days may be referred to a collection agency. You will be responsible for any and all costs associated with the collection agency up to and including all legal costs. **Patients with account balances in excess of 120 days with no payment arrangements or hardship request may be discharged from the practice**. If this occurs, you will have 30 days to seek alternative medical care and our physicians will only be able to treat you on an emergency basis.

I understand the above financial policy. I give consent to KOSM to bill my insurance carrier and agree that I am financially responsible for any and all charges whether or not they are covered by insurance.

_____ _____

Signature of Patient or Legal Guardian Date

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize KOSM and its staff to administer such treatment as is necessary, and to perform services and/or procedures as are considered necessary on the basis of findings during the course of delivery of health care services and treatment.
I have read a fully understand the above Authorization to Treat, the reasons why the treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative methods of treatment which have been explained to me. I also certify that no guarantee or assurance has been made as to the results that may be obtained by services received at KOSM.

Print Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

NARCOTIC PAIN MEDICATION AGREEMENT

Patient Name: _____Patient Date of Birth: _____

Thank you for choosing Kentucky Orthopedics & Sports Medicine. As part of your treatment, you may receive a prescription for a narcotic pain medication. It is intended for short-term use only.

This office may prescribe narcotic medication for patients in conjunction with their treatment plan. Narcotics will be prescribed not to exceed a three-month period of time. If narcotic medication is needed after that time, you must obtain the prescription through your primary care provider or a pain management provider. This is for the safety of the patient due to medications interacting with long-term medication and possible testing required when using narcotic medications. If you are a surgical patient, narcotic medication may be prescribed before surgery and up to three months postoperatively. During treatment if you cancel or do not show for an appointment, narcotic medication will not be provided prior to discussion with your provider.

Kentucky state law, effective July 20, 2012, requires that a drug profile, the "KASPER" report, must be obtained for each patient who receives a narcotic pain medication or refill. The KASPER report includes information on prescription drug use, frequency and number of refills, prescribing physicians as well as dispensing pharmacies. These reports will be reviewed by your physician and will be included in your medical record.

Narcotic side effects include constipation and interference with urination. Sleep and behavior disturbances may occur. Reduced alertness may interfere with operation of a motor vehicle or create other safety hazards. Its long-term use is associated with dependence and increased tolerance; in other words, addiction. Overdose can be fatal. It is your responsibility to use this medication only as needed for severe pain, and only as directed. You should notify the office immediately of any severe side effects.

NARCOTIC PRESCRIPTION POLICY

- No prescription will be filled after business hours, 8 am-5pm, Monday- Friday. Allow 2-3 business days for refill authorization of current prescriptions.
- You should never take narcotic pain medication from more than one prescribing physician, and refills, if any, should be obtained from the same pharmacy.
- This medication should not be given to others under any circumstances. Take your medication only as directed.
- Early refills will not be authorized.

I understand the risks and benefits of using narcotic pain medication. I consent to the treatment and agree to use the medication as prescribed by my physician. I understand that, if I violate any of the above conditions, my controlled substance prescriptions may be immediately terminated. If the violation involves obtaining controlled substances from another individual, or providing controlled substances to another individual, I may also be reported to my other healthcare providers, medical facilities and law enforcement officials. I have read this contract and have also been informed regarding psychological physical dependence to controlled substances. Print Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____