ARTHRITIS & OSTEOPOROSIS CENTER OF KY
789 EASTERN BY - PASS, SUITE #17
RICHMOND, KY 40475

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____/____/_____ Social Security Number: _____/_____/_____

For reminder calls please select which you would like to be contacted as primary or secondary below:

Cell: (_____) _____-_____ Primary or secondary? Okay to leave detailed messages Y N

Home: (_____) _____-_____ Primary or secondary? Okay to leave detailed messages Y N

Spouse Information:

Name: _____ Date Of Birth: _____

Telephone: (___) _____-_____

Whom may we discuss your health information with? Please enter (even spouse) who we can speak with about your account below. We will not discuss information with anyone unless we have the information below filled out:

Name: _____ (relationship) _____ Phone# (____)____-_____

Name: _____ (relationship) _____ Phone# (____)____-_____

Favorite Pharmacy for Medications:

Name: _____ Tel: (___) ____-_____ City: _____

ACCESS YOUR INFORMATION ONLINE WITH

PATIENT PORTAL

YOU CAN VIEW YOUR INFORMATION, MAKE CHANGES AND BE ABLE TO COMMUNICATE WITH THE STAFF BY SENDING SAFE AND SECURE MESSAGES.

YOU WILL RECEIVE AN EMAIL WITH LINK TO THE SITE. ONCE YOU CLICK ON THE LINK YOU WILL BE PROMPTED TO ENTER LOG IN AND PASSWORD. YOUR LOG IN IS ALWAYS YOUR EMAIL ADDRESS. WE WILL PROVIDE YOU WITH A TEMPORARY PASSWORD. YOUR USERNAME AND PASSWORD WILL ALL BE **LOWERCASE**. YOU WILL BE ABLE TO COMMUNICATE WITH THE STAFF EVEN WHEN WE ARE AT OUR OFFSITE CLINICS ON **TUESDAYS** AND **THURSDAYS**.

IF YOU WISH TO USE THE PATIENT PORTAL PLEASE PROVIDE US WITH YOUR EMAIL ADDRESS BELOW:

_____

PASSWORD: (**STAFF WILL PROVIDE YOU WITH ONE**)

YOU WILL BE ABLE TO:
VIEW YOUR INFORMATION ONLINE, LAB RESULTS, REQUEST REFILLS, SEE YOUR APPT DATE AND TIME, EMAIL US WITH CHANGES OR SIMPLY COMMUNICATE WITH OFFICE STAFF. IT WILL DECREASE YOUR WAIT TIME FOR A RESPONSE.

Arthritis & Osteoporosis Center of Kentucky
789 Eastern ByPass, Suite 17, Richmond, KY-40475
Tel: 859-623-5500
Fax: 1-833-249-5207
www.arthritisky.com

****PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT****
*****PLEASE BRING A LIST OF YOUR MEDICATIONS*****

Name:_____ **D.O.B**._____ **Age**:_____ **Marital Status**:_____ **Sex**: Male / Female :

For Females: Are you on birth control: Yes / No: Any chance you are pregnant: Yes / No

Address:_____ **Zip Code**_____

FAMILY DOCTOR: **REFERRING DOCTOR**:

Briefly describe your present symptoms and diagnosis OR Reason for this Consultation:

Medical conditions Diagnosed other than described above

Surgeries / Operations, You had

Current Medications:

Allergies to Medications (Medications you can not take)

Personal History: Occupation:_____ Alcohol Use:_____

Smoking / Tobacco Use: **Please circle**: Ex-Smoker: Current Smoker: Yes / No

- Do you smoke: Every day / Only some days.
- How many cigarettes you smoke daily? ----------
- How many years you have been smoking? ----------

FAMILY HISTORY: (Please circle) (DO NOT INCLUDE YOURSELF)

Mother Living, Deceased. Medical Conditions:

Father Living, Deceased. Medical Conditions

Siblings: Medical Conditons:

Does anyone in your family Has / Had

Lupus / Autoimmune disease:
Rheumatoid arthritis:
Psoriasis / Psoriatic Arthritis:
Osteoporosis / Ankylosing Spondylitis

Please encircle if you currently have or in the past had any of the following:

Diagnosed or Treated for:

- Sexually Transmitted Diseases
- Hepatitis
- HIV
- Tuberculosis
- Anemia
- Any kind of cancer
- Thyroid Disease
- Diabetes
- Blood clots

Did you have Vaccinations: **(Please circle)**

Hepatitis A, Hepatitis B, Pneumonia, Shingles, MMR, Flu (Nasal), Flu (injection) Polio, Meningococcal, Smallpox, Chicken pox, Yellow fever , BCG

REVIEW OF SYSTEMS (Please check or encircle positive symptoms).

General:

- Difficulty sleeping
- Loss of appetite
- Loss of weight
- Low energy level
- Fatigue

Mouth, Nose, Eyes and Ears:

- Dry mouth
- Mouth sores
- Nose sores
- Dry eyes
- Red eyes
- Hoarseness of voice
- Pain in jaws or tongue while chewing food

Skin:

- Rash
- Skin ulcers
- Skin tightening
- Hair loss
- Lumps or knots under the skin
- Color changes in hands and feet with cold

Heart and Lungs:

- Chest pains
- Shortness of breath
- Swollen legs
- Cough
- Blood in sputum
- Wheezing

Gastrointestinal:

- Nausea / Vomiting
- Stomach pains
- Diarrhea
- Blood in stool
- Difficulty swallowing food
- Constipation

Nervous System:

- Headaches
- Loss of vision
- Memory Loss
- Numbness of arms or legs
- Urine or stool incontinence
- Weakness of arms or legs

Kidney and Genitalia:

- Urinary infections
- Kidney stones
- Vaginal or Penile discharge
- Rash on genitalia
- Pain or burning urinating
- Blood in urine

Endocrine:

- Cold intolerance
- Heat intolerance
- Excessive thirst
- Passing excessive urine

Allergic and Immunologic:

- Seasonal allergies
- Sinusitis

Muscles and Joints:

- Muscle pain
- Muscle stiffness
- Muscle weakness
- Morning stiffness
- Joint pain
- Joint swelling

Psychiatric:

- Mood swings
- Depression

Physician Initials with date:

Disability, work related injuries, functional capacity, or auto related injuries:
Please take note that we DO NOT perform examinations for these, and we do not fill any forms relating to these conditions.

Insurance Claims:
We participate with numerous insurance plans and will gladly file your claims 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.

Insurance plans requiring a referral:
Please check with your insurance plan to see if a referral or pre-authorization *is* required from your primary care doctor to see a specialist. 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 obtaining your required referral.

Adult students covered by parent's insurance plan:
We will gladly file your claims however if you are over the age of 18, you are responsible for your bill. We will need your current address and your payment billing address for our records.

Patients without insurance coverage:
Unless prior arrangements have been made, payment in full is due on the day of service. We do not charge interest on unpaid balances; therefore, we cannot extend credit for more than 90 days.

Returned checks:
We charge a $30.00 processing fees for all returned checks due to bank processing fees. Any returned check must be paid within 10 days or it may be turned to a collections agency.

Privacy:
I have been offered and/or received a copy of Arthritis & Osteoporosis Center of Kentucky's Notice of Privacy Practices.

Consent & Authorization:
I hereby give my permission to Arthritis & Osteoporosis Center of Kentucky for the evaluation and treatment of the presented rheumatologic condition. I hereby authorize the above physicians 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 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, if it is part of my protected health information.

The provision of treatments may include infusions, injections, admission in the hospital or any other procedures including workup as considered appropriate for my medical condition

I have read the financial consent and privacy policy statements for Arthritis & Osteoporosis Center of Kentucky and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

I consent to retrieve my prescribed medications by other providers via electronic health records.

Office Policies and Procedures

No Show Policy:
There is a **$25.00 Fee** for each missed appointment. After (**2)** no shows, you will be **dismissed** from the practice. You will then have to contact your Primary Care Physician for your care.

Refill Policy:
Please contact your pharmacy to request a refill request 2 weeks before your last dose so you may have your prescription refilled and ready for pick up. Please do not call the office as the office requires a refill request from the pharmacy for Dr. Ahmed to sign off on. Please keep your appointments to avoid any denied prescription requests.

Phone calls:
Due to the **high call volume** we receive and the amount of patients we care for throughout the day, it is impossible for us to personally answer all the phone calls. If you will leave a message on the correct extension (so your call is not delayed), we will return your call as quickly as we can. If it is an emergency and cannot wait, please visit your nearest emergency room or call 911.

Test Results:
We will only call if results require immediate attention. We **DO NOT** give results over the phone. Dr. Ahmed will go over in detail on your next appointment.

Patient Portal:
We encourage you to visit the patient portal website if you have misplaced your appointment date and time, need to update information, or send us an email if you prefer. It may quicken the response instead of leaving telephone messages.

Collections:
Please be advised that in order for the office to provide the best service to our patients, Arthritis and Osteoporosis center of KY requires a credit card in our files. In the event an insurance carrier has put an amount towards your responsibility after we have billed your insurance carrier (s), we will be happy to bill you for the amount. It is my responsibility to contact the billing office, if I cannot make a payment in a timely manner, and we will be happy to assist you in a payment plan. I understand that if for any reason the account is turned over to a collection agency, I will be responsible for the collection fee and should non-payment of my account result litigation, the collection fee shall increase because of added attorney fees, I will also be responsible for court cost and service of summons cost. In the event I have paid collections in full, and decide to make a new appointment with Arthritis and Osteoporosis Center of Ky, there will be a reinstatement fee of $25.00 upon day of visit a 30% that was sent to collections due to collect losses to the practice. If there is an overdue balance on your account, there is a **10.00 Fee** as we make every attempt for collection i.e. statement, phone call, patient portal, and collection letter.

Primary Care Physician:
Please note the physician will limit your care to rheumatoligical conditions. You will have to contact your Primary Care Physician for any other conditions.

I, the patient, have read, understood and agree to these terms.

Signature: _____In the event your account is overdue after the 3rd statement, we will charge the credit card provided on file the amount due plus whatever your charges are on the overdue account since we were unable to collect from you the patient.