Lake Cumberland Family Care

30 Tower Care
Somerset, Kentucky 42503

We would like to welcome you to Lake Cumberland Family Care! It is our pleasure to be given this opportunity to serve you.

Our office offers a state-of-the-art electronic medical system (EMR) which includes electronic prescription writing (e-Prescribe) that sends prescriptions directly to your pharmacy and checks on drug-to-drug interactions to insure the safest medication prescribing we possibly can.

We provide full medical care from age 15 and up. Our service includes women's health, preventative health care, complete physical/sports exams, vaccinations, comprehensive diabetes and high blood pressure treatment, travel medicine, non-narcotic treatment of pain, joint injections, cryo therapy (freezing) of warts and pre-cancerous skin lesions, minor surgery, EKG testing and more.

Office Hours:

Monday, Wednesday, Friday	8 am-5:30 pm
Tuesday	8 am-6:30 pm
Thursday	10 am-7 pm

Phone #: 606-451-8644 **Fax #:** 606-451-9644
Website: www.lcfamilycare.com

For questions concerning your health, medications, testing or follow up care please contact our nurses **Jane** or **Shelley** during regular office hours. **Nia** is happy to assist you with questions or concerns regarding scheduling, insurance and any other questions that may arise.

If you have a significant medical problem that occurs after office hours, please call 911 or go to your nearest emergency room for evaluation and treatment.

If you have medical needs after office hours not requiring hospitalization, please go to a local urgent care center or emergency room or call the office at opening time the next day so that we can get you in to be seen as soon as possible.

For illnesses requiring hospitalization, we work with and admit thru the hospitalists (doctors whose sole job is to take care of hospitalized patients) at Lake Cumberland Regional Hospital. Hospitalists are specialists in the complexities of hospital medicine and will care for you thru your entire hospital stay.

We will be working closely with them to provide you with the best treatment possible. Upon your discharge from the hospital we will see you in our office to continue your ongoing treatment and address any new issues arising from your hospitalization. Typically, the hospitalist will recommend follow up in 1-2 weeks. Please, as soon as possible after your discharge, call our office to schedule a follow up appointment.

Additionally, we will be working with and consulting the best specialists in the area to get you the care you need when you need it.

Upon making an appointment with us, it is very important that you show up for your appointment as scheduled and come to your appointment on time. When patients miss appointments or show up late, it is not only difficult for our staff but also for other patients who are waiting to be seen or trying to make an appointment. We ask, if at all possible, please try to cancel appointments at least 2 days in advance so that the appointment can be given to someone else. For those who are 10 minutes late (excluding special circumstances), we will have to reschedule. If you are running late, please call us. Thank you for your understanding and help as we try to provide the best, most effective on-time care for all of our patients.

We are here to help you! If you have any financial questions, concerns about medication side effects, costs of medications, or anything else, please feel free to talk with Dr. White or one of the other staff. Not only do we want to be your primary care giver but your advocate in an increasingly complicated medical world. We want your medical care to be as stress free and effective as possible.

Sincerely,

Barry T. White, M.D.
Sandra L. Braswell, APRN
Melissa B. Cheng, APRN

Today's Date ____/____/_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle	Birthdate / /	Age Sex ◻M ◻F ◻T
Is this your legal name? ◻ YES ◻ NO / If not, what is your legal name?	Home Phone Number ( )	SS#
Street or Mailing Address (circle one) City State Zip Code		Cell Phone Number ( )
E-Mail Address	Child lives With:	
Siblings (Name and Date of Birth):		
Student Status: ◻F – Full-Time Student ◻P – Part-Time Student ◻N – Not a Student **School Attended**:		
Race: ◻American Indian/Alaska Native ◻Asian ◻Native Hawaiian/Pacific Islander ◻Black/African American ◻White ◻Hispanic ◻Other ◻Declined **Ethnicity:** ◻Hispanic or Latino ◻Not Hispanic or Latino ◻Declined **Language:** ◻English ◻Spanish ◻Indian ◻Japanese ◻Chinese ◻Korean ◻French ◻German ◻Russian ◻Other _____		
Pharmacy:	Do you have a living will? ◻ YES ◻ NO	
Referred By (Please check one box) ◻ Dr. _____ ◻ Insurance ◻ Hospital ◻ Family ◻ Friend ◻Yellow Pages ◻ Other _____		
Other Family Members Seen Here		
PCP Name	Phone #	

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION

Responsible Party: Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )
Occupation / Employer	Employer Address	Employer Phone Number ( )
Second Parent/Guardian Information: Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )
Occupation / Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ◻ WORKERS COMPENSATION (WC)
◻ OCCUPATIONAL MEDICINE (OM) ◻ MOTOR VEHICLE ACCIDENT (MVA) ◻ ACCIDENT DATE _____

Does the patient have healthcare coverage? ◻ YES ◻ NO	Insurance Name				
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Child ◻ Other _____					
Name of Secondary Insurance	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ◻ Self ◻ Spouse ◻ Child ◻ Other _____					

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

New Patient Information

Please fill out this form as it applies to you

Patient Name:_____ **Date:**_____

Reason for today's visit:_____

Medical Problems:	Patient	Family	Relation
1. Acid reflux/heart burn	0	0	_____
2. Anxiety/depression	0	0	_____
3. Asthma	0	0	_____
4. Arthritis/joint problems	0	0	_____
5. Cancer_____	0	0	_____
6. Chronic pain	0	0	_____
7. Diabetes	0	0	_____
8. Emphysema/COPD	0	0	_____
9. Heart disease	0	0	_____
10. High blood pressure	0	0	_____
11. High cholesterol	0	0	_____
12. Kidney disease	0	0	_____
13. Thyroid disease	0	0	_____

14. Other_____

Surgeries (with dates)

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Previous Health Care (please provide dates)

1. Last colonoscopy_____ Result:_____

2. Last prostate check_____ Result:_____

3. Last Pap Smear_____ Result:_____

4. Last mammogram_____ Result:_____

5. Immunizations: Tetanus_____ Pneumonia_____ Shingles_____Yearly Flu_____

Specialists (please list)

1._____ City:_____ 4. _____City:_____

2._____ City:_____ 5._____City:_____

3._____ City:_____ 6._____City:_____

Allergies _____

Current Health Habits

1. Do you or have you ever smoked? Y/N How many packs/day____When quit?_____

2. Do you drink alcohol? Y/N Daily___Weekly___Social___ How much?_____

3. Have you ever used illegal drugs (either experimental or regular use)? Y/N

Which drugs?_____

4. What types of exercise do you do?_____How often?_____

Social History (please circle)

1. Married/Single/Widowed/Divorced. If divorced, how many times?_____

2. Children? Y/N How many?_____ Grandchildren Y/N How many?_____

3. Health of spouse (if married) Excellent/Good/Fair/Poor

4. Hobbies/interests_____

5. Employed/Retired/Unemployed If employed, what is your trade?_____

6. Disabled If so, for what reason(s)_____

LAKE CUMBERLAND FAMILY CARE
HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may *talk* to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

_____ _____

_____ _____

_____ _____

I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

_____

Date

Lake Cumberland Family Care

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid on the day of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill.

3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

4. If payment is not received within a reasonable amount of time from the guarantor or if we receive returned mail as undeliverable we will place your account with an outside collection agency.

5. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

6. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.

7. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

8. **ADVANCE DIRECTIVE:** □ I have executed an Advance Directive □ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

_____ _____

Signature of patient, legal representative for health care services Date

If other than patient

_____ _____

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent