Bluegrass Med Care

Primary and Preventative Medicine

Name_____
First Middle Last Suffix

Address_____ Apt #_____

_____ Zip Code_____
City State

Primary Phone #_____ **Email address**_____

Date of Birth_____ **Social Security Number**_____

Employer_____

Pharmacy_____ **Location**_____

Emergency Contact Name_____ **Phone #**_____

Relationship to you_____

Who is financially responsible?

- **Self**
- **Other – Name**_____ Phone#_____

Method of payment

- **Cash pay**
- **Insurance**

Primary Insurance Policy _____ **Policy #**_____
Insurance Company

Group#_____

*****If you are not the primary policy holder, please fill out the following:**

Name_____ **Date of Birth**_____

Policy # (if different) _____ **Social Security Number**_____

Secondary Insurance Policy_____ **Policy #**_____
Insurance Company

Group #_____

*****If you are not the secondary policy holder, please fill out the following:**

Name_____ **Date of Birth**_____

Policy # (if different) _____ **Social Security Number**_____

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Primary and Preventative Medicine

HIPAA PRIVACY CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has the Notice of Privacy Practices and that the patient has the opportunity to review them.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records and claims information. This may be released to the following:

- Spouse_____
- Children_____
- Other_____
- Information is not to be released to anyone

Please call my:

- Home_____
- Work_____
- Cell_____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- other_____

This release of information will remain in effect until terminated by me in writing.

_____

PRINTED NAME AND SIGNATURE - Patient or Responsible Party Relationship to patient

_____

Practice Representative Date

Bluegrass Med Care
Primary and Preventative Medicine

Appointment/Cancellation/No Show Policy/Payment

Appointments

Office visits are by appointment only, please call 270-843-5662. The receptionist will ask about the reason for your visit. This helps us schedule our providers' time more efficiently. Please arrive 15 minutes early for your appointment. Patients who are late for any appointment may be asked to reschedule. This is at the providers' discretion. Please remember to bring all your prescriptions, including over-the-counter medicines, vitamins, and supplements to each appointment. It is important that we maintain an updated list for the providers to view at each visit.

Cancellations

We would like to thank you for being a patient at Bluegrass Med Care. We value all our patients and strive to provide the best care possible. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us a 24-hour notice. If this is not possible, please let us know as soon as you can. This courtesy makes it possible to give your reserved time to another patient.

Missed Appointments (non-cancelled appointments)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is unnecessarily delayed. We track missed appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling 24 hours before the scheduled time. This fee is also at the providers' discretion. After 3 missed appointments, there will be a charge of $20 from that date forward. Insurance will not cover charges for no show/late or late cancellation fees. This charge will be in addition to any other charges you may have incurred at this office and no refunds will be given. Repeated missed appointments may result in being discharged from this practice. We will offer 30 days of emergent care only and transfer your medical records when you find a new provider.

Payment

Payment (including all copays and outstanding balances) is due at time of service. Please notify our staff if you are experiencing significant financial difficulties to discuss other possible arrangements.

If sent to Collection, you agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33.3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fee incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing.

PRINTED NAME AND SIGNATURE – Patient or Responsible Party Relationship to patient

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Practice Representative

Bluegrass Med Care
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I, _____ voluntarily consent to an authorize my health care provider _____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.
Recipient: I authorize my health care information to be released to the following recipient(s):

Name: Bluegrass Med Care **Fax: (270) 843-5614**

Purpose: I authorize the release of my health information for the following specific purpose: at the request of patient signed below.
Information to be disclosed: I authorize the release of the following health information: information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ Only the following records or types of health information:

_____.

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20___.
☐ Until the Provider fulfills this request.
☐ Until the following event occurs: _____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal & state law governing the use and disclosure of my health information.
Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Bluegrass Med Care. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Bluegrass Med Care Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.
Questions: I may contact the Bluegrass Med Care Office of Compliance for answers to my questions about the privacy of my health information at 4863B Scottsville Rd., Bowling Green, KY 42104, or by telephone at (270) 843-5662.

_____

Signature Date of Birth

If Individual is unable to sign this Authorization, please complete the information below:

_____

Name of Guardian Legal Relationship

_____

Practice Representative Date