ORTHO KENTUCKY, PLLC

Kentucky Bone & Joint Surgeons
216 Fountain Ct, Ste 250
Lexington, KY 40509
859-276-5008

Orthopedic Consultants
1760 Nicholasville Road, Ste 604
Lexington, KY 40503
859-255-9059

Name | Birthdate | Sex

Address | Soc Sec #

City | State | Zip | Ethnicity | *Non-Hispanic or Hispanic* | Race

Home Phone | Cell Phone | Work Phone | Marital Status

Email | Employer

Emergency Contact | Phone #

Referring doctor:

Are you in or on leave from a nursing facility? Yes or No | Name of Facility

Worker's Compensation/Auto Information

Is your injury work or auto related? | Has a claim been filed? | Claim #

Place of accident/injury | Date of Injury

Contact Name | Phone Number

Insurance Information

Primary Insurance: | Policy #: | Group #:

Policy Holders Name | Birth date

Soc Sec # | Relationship to patient

Secondary Insurance: | Policy #: | Group #:

Policy Holders Name | Birth date

Soc Sec # | Relationship to patient

- I give my permission for Ortho Kentucky, PLLC physicians to render treatment to me/my dependent. I understand that I will be given all available pertinent information, prior to treatment being rendered. I understand that I may decline recommended treatment at anytime, but if I choose to do so, it is at my own risk.
- Permission is, hereby, granted to Ortho Kentucky, PLLC physicians to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment, and/or my referring family physician. Permission is here granted to any facility where I have previously been treated to release medical records/x-rays to Ortho Kentucky, PLLC.
- I authorize insurance payment benefits to Ortho Kentucky, PLLC physicians for services rendered. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me. This includes but is not limited to co-insurance, co-payments, deductibles, and non-covered services.
- I further acknowledge Ortho Kentucky, PLLC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by them, as well as other rights I have regarding my protected health information.

_____ _____ _____

Patient (or Guardian) Signature | **Relationship to Patient** | **Date**

Sign if over 18 unless you have POA, if POA please attach a copy of the order

Allergies and Current Medications

Patient Name:_____ **DOB:**_____

Medication Allergies:_____

_____

_____

_____

_____

Current Medications, include dosage and frequency and any over the counter meds and herbal supplements: ☐ **List is attached** _____

_____

_____

_____

_____

_____

Current Pharmacy, address and phone number:

_____

Have you had the flu shot, date:_____

Have you had the pneumonia shot, date:_____

Signature:_____ **Date:**_____

Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Ortho Kentucky, PLLC dba Kentucky Bone and Joint Surgeons (KBJS) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of KBJS.

I have the right to revoke this consent, in writing, at any time, except to the extent that KBJS has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review KBJS's Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of KBJS. The Notice of Privacy Practices for KBJS is also provided in the lobby and on the group website at www.kybones.com. This Notice of Privacy Practices also describes my rights and the KBJS duties with respect to my protected health information.

I acknowledge that my health history will be submitted to the state's syndromic registry as required by the Affordable Care Act via an encrypted connection.

I acknowledge that my records are stored in an electronic format. I understand KBJS maintains their patient records in electronic format only. Original documents are destroyed after being converted to an electronic format.

KBJS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices.

I understand the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Rep's Authority

Parent or Personal Representative refused to sign acknowledgement

_____ Staff Initials

_____ Date

Trade Name Disclosure: Kentucky Bone and Joint Surgeons and KBJS are legal trade names of Ortho Kentucky, PLLC

Authorization to Release Information

As referred to in the Privacy Practices, you have the right to restrict who will have access to your PHI. At the same time, this limits our ability to communicate PHI without your ***written*** consent, even to family members who have may be contacting us on your behalf. Please take the time to use this section to authorize release of information to anyone of your choice.

I authorize the release of my information, including any PHI, by Kentucky Bone and Joint Surgeons, to the following:

Name	Relationship		All information	Scheduling	Billing	May Pick up medication RX

You may also leave any information on my voicemail? YES NO

My PHI may be release to the above people as authorized effective from data signed until such time I revoke in writing.

_____ _____ _____

Patient (or Guardian) Signature **Relationship to Patient** **Date**

Sign if over 18 unless you have POA, if POA please attach a copy of the order

Kentucky Bone & Joint Surgeons
Orthopaedics & Sports Medicine

A Division of Ortho Kentucky, PLLC

Kaveh Robert Sajadi, MD
Sam Coy, MD
216 Fountain Court, Suite 250
Lexington, KY 40509
Phone: 859-276-5008
Fax: 859-278-6401

FINANCIAL POLICY

Thank you for choosing our practice. We are 100% committed to the care of our patients. We are happy to answer any financial questions that you may have. Please understand that payment of your bill is expected as part of your treatment plan, and review this policy in full to ensure that you understand before consenting to treatment. You are responsible for any balance on your account not paid by any third-party payer(s) including insurance, worker's compensation, etc. If you have any questions, please contact our Practice Administrator.

Co pays and deductibles are due on the day of service. We accept cash, check, Visa, MasterCard and Discover. We participate with most major insurance companies. If your insurance requires a referral, please make arrangements to obtain one before your appointment. Without the referral on file, you may have to reschedule. If you are unsure if we are on your participating provider list please call the customer service number on your insurance card. Please remember you are responsible for any balance not paid by your insurance company.

For patients who are private pay we expect payment in full at time of services. Certain services such as cast boots, fracture walkers, ace bandages, heel pads, etc are not always covered by insurance policies. If these items are not covered you will be responsible for payment.

We do have a service fee of $50.00 for each returned check and all balances are due within 30 days after your insurance has paid. All past due balances are subject to attorney's fees and any other legal fees incurred as part of our attempt to collect a debt. Delinquent account status could result in you being asked to seek treatment with another Orthopaedic practice.

We appreciate your understanding and cooperation.

I have read and understand the above financial policy. I understand I am responsible for any balances not covered by my insurance company. I authorize Kentucky Bone & Joint Surgeons to be paid directly by my insurance. I authorize Kentucky Bone & Joint Surgeons to release any medical records to my insurance company when requested, or to facilitate payment of a claim. I authorize Kentucky Bone & Joint Surgeons or its agents, unless I notify the office to the contrary in writing, to utilize any means of communication I provide to contact me, including but not limited to wireless telephone, text, email, etc. I understand that information may be sent via communication methods I provide regarding billing, payment, marketing materials for new services, etc.

DATE	SIGNATURE	PRINTED NAME