CASA SAN PIO OF APPALACHIA

Revised Oct 2019

1 PATIENT INFORMATION

Name (First, Middle, Last): _____

Date of Birth: _____ Social Security Number: _____-_____-_____ □ Male □ Female

Status: □ Minor □ Single □ Married □ Widowed □ Separated □ Divorced Spouse/Parent Name: _____

Race: □ White/Caucasian □ Black/African American □ Hispanic □ Asian □ Other _____

Preferred Language: _____ Do you require a translator? □ Yes □ No

Mailing Address: _____

City, State: _____ Zip _____

Phone: (_____)_____ Cell Phone: (_____)_____

Physical Address (If different from mailing): _____

2 GUARANTOR INFORMATION

IF OTHER THAN SELF or UNDER 18

Relationship to Patient: □ Spouse □ Mother □ Father □ Grandparent □ Legal Guardian

Name (First, Middle, Last): _____

Date of Birth: _____ Social Security Number: _____-_____-_____ □ Male □ Female

Mailing Address: _____ □ Mark if same as above

City, State: _____ Zip: _____

Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (____)_____

Other Parent Information:

Relationship to Patient: □ Mother □ Father □ Grandparent □ Legal Guardian □ Other

Name (First, Middle, Last): _____

Date of Birth:_____ Social Security Number: _____-_____-_____ □ Male □ Female

Mailing Address: _____ □ Mark if same as above

City, State: _____ Zip: _____

Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (____)_____

** Pending the providers' evaluation there is NO guarantee that you will be prescribed a controlled substance**

3 EMERGENCY CONTACTS

PLEASE LIST AT LEAST ONE CONTACT

1. Name: _____ Relationship: _____

   Phone: (_____)_____ Cell Phone: (_____)_____

2. Name: _____ Relationship: _____

   Phone: (_____)_____ Cell Phone: (_____)_____

3. Name: _____ Relationship: _____

   Phone: (_____)_____ Cell Phone: (_____)_____

4 EMPLOYMENT INFORMATION

Employment Status: □ Currently Employed □ Unemployed □ Self-Employed □ Disabled □ Other

Name of Employer/Workplace: _____

Address:_____

City, State: _____ Zip: _____

Phone: (_____)_____ Other Contact Information: _____

5 PATIENT PORTAL

By providing an E-mail address you can sign up for Casa San Pio of Appalachia Patient Portal, which allows you to:

- Review you Medical Record & Personal Health Information
- Access your test results
- View your visit summaries
- Communicate without practice, and more!

E-Mail Address:_____

6 CONSENT FOR TREATMENT

Revised Oct 2019

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified(s)*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) you consent to treatment at this office or any other satellite office under common ownership; and (3) you understand and consent that in the event of an emergency or other illness, the Providers and staff of Casa San Pio of Appalachia will deliver any medical care deemed necessary. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test of treatment recommended by your health care Provider, we encourage you to ask questions.

I voluntarily request a Physician and/or Mid-Level Provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care Providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this Practice. I understand that if additional testing, invasive or interventional procedures are recommended I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s)

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Parent/Guardian/Personal Representative if applicable:

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness

Witness Printed Name: _____ Date: _____

Signature: _____

7 CONSENT TO TREAT MINOR

IF UNDER AGE 18

As the parent/legal guardian of the following child:

Name _____ Date of Birth _____ SS# _____

I hereby authorize and consent to the examination and/or treatment of my child during office and facility visits by the providers and clinical staff of Casa San Pio of Appalachia. In addition, I give permission for the following person(s) to bring my child to Casa in my absence and to act on my behalf in authorizing medical care and treatment. In the event of an emergency or other illness, I understand that the physicians and staff of Casa will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, Casa will assume that the child's biological and/or legal parents are both legal guardians who have access to treatment option and medical information for that child.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Medical Records / Privacy

At Casa San Pio of Appalachia, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of Casa securely kept, and are accessed only for purposes outlined by the HIPAA Notice Policy. Records may be released or shared with other health care providers for treatment of your child. Patients are entitled to a copy of their medical records after an authorization for release is signed.

- I have received a copy of the HIPAA Notice from Casa San Pio of Appalachia.
- I understand that Casa may call my home and place of employment for health care reasons, appointment reminders and to resolve bill issues.
- I understand that Casa may fax immunization certificates, school excuses, physical/sports forms and /or medication instructions to my personal or work fax, or mail to my home. Casa cannot fax or send these documents to third parties without my permission.
- I understand that Casa my leave messages on my answering machine and/or voicemail regarding appointments and limited lab information.
- I understand that Casa may discuss patient information with adults or minors present during the visit.
- I understand and agree to all the above unless I strike through one of the statements.

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness

Witness Printed Name: _____ Date: _____

Signature: _____

8 HIPAA POLICY

I acknowledge that I was provided with a copy of Casa San Pio of Appalachia's HIPAA Privacy Notice, which describes how my medication information may be used and disclosed. I understand that I may request additional copies at any time.

Printed Patient Name: _____ Date: _____

Signature: _____

Witness

Witness Printed Name: _____ Date: _____

Signature: _____

9 PAYMENT / BILLING POLICY

PAYMENT POLICY

Thank you for choosing us to take care of health needs. We are committed to providing you with quality and affordable health care. Because you may have questions regarding payment for services rendered, we have developed this payment policy. Please read it and feel free to ask any questions you may have. A copy will be provided to you upon request.

- **INSURACE** – We accept most insurance, including Medicare and Medicaid. If you are insured by a plan we are not contracted with, or, if you do not have a current insurance card with you, you may be responsible for payment.
  Knowing your insurance benefits **is your responsibility. Please contact your insurance company with any questions you have about your coverage.**
- **COPAYS & DEDUCTIBLES** – Co-Pays and Deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.
- **NON-COVERED SERVICES** – Please be aware that some services you receive may not be covered by your Plan. You may be responsible for payment of those services. Questions about non-covered services should be directed to your insurance company.
- **PROOF OF INSRURANCE** – Please complete our patient information forms and provide us with a copy of your insurance card before being seen. We must be able to verify coverage before services are rendered.
- **CLAIMS SUBMISSION** – We will submit your claim in full, such as when a balance is applied to Copay, Coinsurance, or Deductible, that balance should be paid at your next visit. Payment arrangements can always be made to suit your budget.
- **COVERAGE CHANGES** – If your insurance coverage changes, it your responsibility to provide us with that information.
- **CHARGES** – Please be aware that our fees are representative of the usual and customary fees for our area.
- **We accept Cash, Check, Visa, Discover, and MasterCard (credit and debit).**
- **A $25 fee will be charged for any check returned for insufficient funds.**

BILLING POLICY

Casa San Pio of Appalachia will bill any treatment you receive to your primary and secondary insurance companies. We allow 60 days for insurance to pay and if after 60 days your insurance has not paid, the balance will then become your responsibility. Payment, which includes copays and self-pay are expected at the time of service. It is your responsibility to know the requirements of your insurance.

By signing below, I acknowledge that I have read and understood the above Payment/Billing Policies and hereby authorize Casa San Pio of Appalachia to treat any necessary information to process such claims.

Printed Name: _____ Date: _____

Signature: _____

10 OFFICE POLICY

Thank you for choosing Casa San Pio of Appalachia for your healthcare needs. Whether your well-being requires attention to a chronic disease, or treatment of an acute illness, it is our goal to comfort, heal, teach and learn as we work to improve your life. Every patient is treated as an individual, with respect, compassion, honesty and fairness.

To ensure good Provider-Patient relationships, please read the following sections carefully to better understand our office policy.

Appointments

We value the time that we have set aside to treat you or your child, as such, we would appreciate a 24-hour notice if you are unable to keep your scheduled appointment.

Please note that if you are late for your appointment (>15mins), we will do our best to accommodate you, however, depending on patient load for that day, it may be necessary to reschedule your appointment for a different day or time.

While we strive to minimize your wait time, emergencies do sometimes occur and take priority. We appreciate your understanding in these cases.

Walk-In Policy

Depending on patient load, Casa reserves the right to request that you come back at a better time and/or date.

Due to patient volume, walk-ins will be seen by the first available Provider, not by request.

Prescription Refills

If you are calling in regard to your regular monthly prescriptions, please note that it may take up to 24 hours to send these into the pharmacy. Please make sure to plan ahead so your prescription does not run out.

Return Calls & After Hours

If you are calling with a medical emergency, you should call 911 or go to the nearest emergency room.

If you are calling after hours regarding a non-urgent matter, please leave your name, date of birth and phone number and we will return your call within 24 hours.

If you are calling with an urgent matter, please call the Provider on call at (859) 813-9010.

Medical Records / Privacy

At Casa San Pio of Appalachia, we are committed to protecting the security and privacy of our patient's personal information. Medical records are the property of Casa, kept securely are accessed only for purposes outlined by our HIPAA Privacy Notice. Records may be released or shared with other healthcare providers for treatment. Patients are entitled to a copy of their medical records after an authorization for release is signed.

- I have received a copy of the HIPAA Privacy Notice from Casa San Pio of Appalachia.
- I understand that Casa may call my home and place of employment for health care reasons, appointment reminders and to resolve billing issues.
- I understand that Casa may fax immunization certificates, work/school excuses, physical/sports forms and/or medication instructions to my personal or work fax or mail them to my home. Casa cannot fax or send these documents to third parties without my permission.
- I understand that Casa may leave messages on my answering machine and/or voicemail regarding appointments and limited lab information.
- I understand that Casa may discuss patient information with adults or minors who may accompany me to office visits.
- I understand and agree to all the above unless I have marked through one of the statements.

I have read, understood and agree to comply with the above office policy. Please feel free to ask questions about anything that you do not understand.

Printed Name: _____ Date: _____

Signature: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME _____ DATE OF BIRTH_____

SOCIAL SECURITY # _____ DATES OF PROFESSIONAL SERVICES _____

1. I HEREBY REQUEST AND/OR AUTHORIZE _____

   TO DISCLOSE THE HEALTH INFORMATION, AS DESCRIBED BELOW, OF THE ABOVE-NAMED PATIENT TO:

2. INFORMATION TO BE RELEASED TO: **CASA SAN PIO OF APPALACHIA (STANTON FAMILY CLINIC, LLC)**

   □ 638 EAST COLLEGE AVENUE, SUITE B STANTON, KENTUCKY 40380 PHONE: (606) 318-3500 FAX: (606) 318-3503

   OR TO THE FOLLOWING PERSON/ORGANIZATION: _____

   _____

3. INFORMATION TO BE RELEASED – CHECK YES OR NO AND INITIAL (MAY INCLUDE SUBSTANCE USE DISORDER RECORDS, IF APPLICABLE)

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		MAJOR EVALUATIONS	
		TREATMENT PLANS	
		APPOINTMENT HISTORY	
		OFFICE NOTES	
		HISTORY & PHYSICAL	
		CONSULTATION NOTES	
		ADDICTION TREATMENT	
		URINE DRUG SCREENS	
		MEDICATIONS	

YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		ORDER & PROGRESS NOTES	
		DISCHARGE SUMMARIES	
		LABORATORY RESULTS	
		RADIOLOGY RESULTS	
		PATHOLOGY REPORTS	
		EMERGENCY ROOM RECORD	
		OPERATIVE REPORTS	
		NURSE NOTES	
		OTHER:	

4. PURPOSE OF RELEASE: □ Personal Interest □ Legal Claim Processing □ Social Security or Disability Claim
   □ Continuity of Care □ Insurance Claim Processing □ Other _____

5. TIME LIMITATION OF RELEASE: THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:
   a. I understand that this authorization will expire □ one (1) year from date of signature □ on the following date _____ / _____ / _____ □ or upon disclosure of the records to the above-named Person/Organization.
   b. I understand that I may revoke this authorization at any time, providing the information has not already been disclosed. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.
   c. I understand that any disclosure of this health information is voluntary, and I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.
   d. I understand that any disclosure of information carries with it the potential for the unauthorized redisclosure by the recipient and no longer protected by federal confidentiality rules.

Prohibition on redisclosure: I understand that this information has been disclosed from records protected by Federal confidentiality rules **(42 CFR Part 2 and 45 CFR Parts 160 and 164**) and/or KY state law. The Federal rules and/or KY state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or KY state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients. The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **INITIALS** _____

6. I UNDERSTAND THERE MAY BE A CHARGE FOR THIS REQUEST AND I WILL BE NOTIFIED OF THE COST BEFORE ANY CHARGES ARE INCURRED.

7. RECORDS OF ROUTINELY MAILED. PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP

   1 PHOTO ID OR 2 OTHER FORMS OF ID: □ SOCIAL SECURITY CARD □ DRIVER'S LICENSE □ SCHOOL/WORK ID □ OTHER _____

Date: _____ Patient Signature_____

Witness: _____ ***If signed by Representative:*** Printed Name: _____

Signature of Legal Representative: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip:_____

REVISED 10/2019

The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent of legal guardian for any other minor or by patient's representative (i.e. Power of attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney. MR-15 Effective 04/14/2003