Versailles Family Medicine

460 Wilson Avenue, Versailles, KY 40383
Phone: (859) 879-0111 Fax: (859) 879-0363

**PEDIATRIC PATIENT INFORMATION**

First Name:_____ MI: _____ Last Name: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

Street Address (if PO Box): _____City: _____ State: ____ Zip: _____

Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____

Date of birth: _____ Social Security Number: _____ Sex:☐Male☐Female

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

Ethnicity: ☐ Hispanic☐Non-Hispanic

Language:☐English ☐Spanish ☐Other _____

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Mother's First Name:_____ MI: _____ Last Name: _____

Mailing Address *(if different from above):* _____City: _____ State: ____ Zip: _____

Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____

Date of birth: _____ Social Security Number: _____

Employment Status: ☐Full Time☐Part Time ☐Self ☐Retired ☐Not Employed

Place of Employment:_____ Occupation: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

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Father's First Name:_____ MI: _____ Last Name: _____

Mailing Address *(if different from above):* _____City: _____ State: ____ Zip: _____

Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____

Date of birth: _____ Social Security Number: _____

Employment Status: ☐Full Time☐Part Time ☐Self ☐Retired ☐Not Employed

Place of Employment:_____ Occupation: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

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Parent's Marital Status:☐ Single ☐Married ☐Divorced ☐Widowed ☐Separated

Custodial Parent, if applicable: _____

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**EMERGENCY CONTACT**

First Name:_____ MI: _____ Last Name: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____

Relationship to patient: _____

## AUTOMATED APPOINTMENT REMINDERS

Versailles Family Medicine is now offering automated phone, text, and email messages for appointment reminders and other office notifications, such as severe weather closings. Please indicate your information below to participate.

*Preferred contact number*: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

*Preferred method of contact*: ☐ Voice call ☐ Text Message (*standard text messaging fees apply*)

*Preferred time of day:* ☐ Morning (9:00am) ☐ Afternoon (3:00pm) ☐ Evening (6:00pm)

## PATIENT PORTAL

VFM has launched a website, known as a patient portal, which contains information and tools such as medical records, refill requests, lab results, etc. We hope this portal, along with the above message notification program, will allow us to keep our patients better informed about their healthcare from the comfort of their own home 24/7.

Please indicate the preferred email address, if any, to receive messages through the patient portal. Upon Versailles Family Medicine entering your email address in our system, our electronic medical record system will automatically generate a username and password for your portal account and email them to you. In the event you lose this username/password, please contact our office.

*Preferred email address*: _____

## INSURANCE INFORMATION

Does the patient have health insurance? ☐ Yes ☐ No

Primary Insurance: _____ Subscriber ID#:_____ Group#:_____

Cardholder First Name:_____ MI: _____ Last Name: _____

Mailing Address (if different from above): _____ _City: _____

State: _____ Zip: _____ Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____

Secondary Insurance: _____Subscriber ID#:_____ Group#:_____

Cardholder First Name:_____ MI: _____ Last Name: _____

Mailing Address (if different from above): _____ _City: _____

State: _____ Zip: _____ Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____

## RESPONSIBLE PARTY

☐ Check box if information is the same as the above emergency contact information. However, please be sure to indicate the responsible party's DOB and SSN below.

First Name:_____ MI: _____ Last Name: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

Street Address (if PO Box): _____City: _____ State: ____ Zip: _____

Home Phone (___)_____ Cell Phone (___)_____ Work Phone (___)_____

Date of birth: _____ Social Security Number: _____ Sex: ☐ Male ☐ Female

Relationship to patient: _____

## PHARMACY INFORMATION

Please indicate your preferred pharmacy below.

Pharmacy Name:_____ Phone Number: _____

Address: _____City: _____ State: ____ Zip: _____

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# PEDIATRIC MEDICAL HISTORY

## BIRTH HISTORY

Did the mother receive prenatal care? ☐ Yes ☐ No

Is the child adopted? ☐ Yes ☐ No

Where was the patient born? Hospital: _____ City/State:_____

Type of delivery: ☐ Vaginal delivery ☐ C-Section

Was the child full term or premature? _____

Please list any complications with the pregnancy or delivery: _____

## PATIENT'S MEDICAL HISTORY

Please list any previous or current health problems the child has/had? Please include chickenpox, if applicable.

| Health issues | When were they diagnosed? |
|---|---|
| | |
| | |
| | |

Does the child have any allergies to medications or foods? ☐ No ☐ Yes

| Medication/Food | Reaction (rash, shortness of breath, etc) |
|---|---|
| | |
| | |
| | |

Does the patient take any medications on a daily/frequent basis? ☐ No ☐ Yes

| Medication Name | Strength | Dose and Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has the child ever been hospitalized? ☐ No ☐ Yes

| Reason for Hospitalization | Hospital Name, City, State | Dates of Admission |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has the child ever had surgery? ☐ No ☐ Yes

| Surgical Procedure | Hospital Name, City, State | Date of Surgery |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## FAMILY HISTORY

Is there a family history of any of the conditions listed below? If yes, please indicate relationship to patient.

| Disease | Relationship to Patient |
|---|---|
| Asthma | |
| Allergies | |
| Bleeding Disorder | |
| Cancer (type?) | |
| Cystic Fibrosis | |
| Diabetes | |
| Epilepsy (Seizures) | |
| Heart issues | |
| Intestinal issues | |

| Disease | Relationship to Patient |
|---|---|
| Kidney issues | |
| Liver issues | |
| Mental Illness | |
| Skin issues | |
| Stroke | |
| Substance Abuse | |
| Thyroid Disease | |
| Tuberculosis | |
| Urinary Tract Issues | |

## PATIENT'S SOCIAL HISTORY

Where does the child attend school or daycare? _____ Grade in school? _____

Does anyone in the home smoke? ☐ No ☐ Yes

Are there any guns in the home? ☐ No ☐ Yes

Are there any pets in the home? ☐ No ☐ Yes

Has the child traveled outside of the United States? ☐ No ☐ Yes, where? _____

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**PATIENT CONSENT FORM**
****THIS MUST BE SIGNED TO BE TREATED!****

- I, the undersigned, hereby consent to the following treatment:
  - Administration and performance of all treatments
  - Administration of any needed anesthetics
  - Administration of recommended vaccinations for a given age group and/or disease state
  - Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
  - Use of prescribed medication, which may include controlled substances
  - Performance of diagnostic procedures/tests, cultures, biopsies and surgery
  - Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based o the judgment of the attending physician or their assigned designees

- I fully understand that this is given in advance of any specific diagnosis or treatment.

- I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

- I understand that Versailles Family Medicine, PLLC may include consent at satellite offices under common ownership.

- I, the undersigned, acknowledge that Versailles Family Medicine, PLLC will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

- A photocopy of this consent shall be considered as valid as the original.

**- MEDICARE PATIENTS:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Versailles Family Medicine, PLLC.

**Patient Initial: _____ I acknowledge that I have been given the Versailles Family Medicine, PLLC Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official**.

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

_____ _____
**Patient Name** **Date of Birth**

_____ _____
**Patient (or Responsible Party) Signature** **Today's Date**

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# CONSENT FOR TREATMENT OF MINOR

I, _____, the parent/legal guardian of the minor mentioned below, voluntarily give consent to Versailles Family Medicine to evaluate and treat _____ (minor's name) born on _____ (date of birth).

☐ At request of the minor – Gives the minor permission to schedule appointments and consent to treatment(s) without parental permission

☐ If accompanied by the individual(s) listed below – Gives the individual(s) named below permission to schedule appointments and consent to treatment(s) without parental permission

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I understand routine medical care, treatment and services may include, but are not limited to: medical evaluation, physical exam, immunizations, x-rays, and diagnostic lab work. I hereby empower and grant the decision maker(s) appointed above, permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed above and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. I further understand that if transfer of my child to a hospital or emergency room is necessary, I authorize the decision maker(s) appointed above, or Versailles Family Medicine should the minor be given permission to be seen unaccompanied, to consent for the hospital or emergency room treatment for my child in my absence. I understand there is no obligation to contact me if the above appointed decision maker is available to consent to this care. The individual appointed as decision maker herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and/or services delivered pursuant to this authorization. This agreement is valid for two (2) years following the date signed below unless withdrawn in writing to Versailles Family Medicine.

Furthermore, I affirm to have received consent from any other parent/legal guardians to provide care as mentioned above.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

Daytime phone: _____ Evening phone: _____

Secondary Parent/Guardian Name (Print): _____

Secondary daytime phone: _____ Secondary evening phone: _____

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# FINANCIAL POLICY

We are committed to providing you the best possible care. In order to better serve you, **Versailles Family Medicine** has adopted the following financial policy. Please read and familiarize yourself with this billing and payment policy to avoid future misunderstandings. If you have questions, please do not hesitate to speak with the billing office.

1. All copayments are due at the time the service was rendered. Should you have an outstanding balance at the time of your appointment, we must collect at least 25% of your outstanding balance plus your copayment to be seen. Furthermore, refills may also be declined if your account balance is past due.

2. All accounts greater than 90 days overdue may be sent to a collection agency. VFM is now contracted with Credit Bureau Systems to collect overdue patient account balances. Our office will continue to contact you via phone and mail during the first 90 days your balance is due. Should you have any questions regarding your bill, please contact our office during this period and we will be glad to help. Failure to pay any outstanding balance may result in dismissal.

   By signing below, you agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies up to 40%. Such contingency fees will be added and collected by the collection agency immediately upon default and referral to the collection agency.

3. The following lists our most popular in-network insurance plans. Please note it is ultimately your responsibility as the patient to contact your insurance company to determine your benefits with VFM. Additionally, VFM may require you to pay the self-pay price if we do not have past experience with your insurance company in case VFM is out of network.

   *Aetna*
   *Anthem BCBS (PPO & Medicare)*
   *Bluegrass Family Health*
   *CIGNA*
   *Humana PPO (NOT Humana Medicare)*
   *Kentucky Health Cooperative (most)*
   *Medicaid (Including Passport)*
   *Medicare (some Advantage plans)*
   *United Healthcare*
   *UMR*

4. If you fail to provide VFM with your insurance card, you will be personally responsible for all charges and may be asked to pay the self-pay charge at the time of your visit and/or ultimately be rescheduled.

5. All uninsured patients are required to pay $75 for a new patient visit and $60 for an established patient visit plus any further lab/procedure charges. All charges are due at the time the service is rendered.

6. All motor vehicle and workers compensation visits require the patient to provide VFM with your claim number, insurance address/phone number, and claims adjuster prior to being seen.

7. Checks returned for non-sufficient funds must be paid in full within 10 days with a $20 non-sufficient funds fee in addition to the amount owed. Failure to pay will result in possible dismissal from VFM and your account being turned over to Woodford County Attorney's Office.

**Please remember! Your medical coverage is a contract between you and your insurance company. You are personally responsible for any unpaid balance by your insurance company.**

**Patient Name: _____ DOB: _____**

**Patient Signature: _____ Date: _____**
**(Responsible party's signature if patient is a minor)**

**PERSONAL HEALTH INFORMATION (PHI) RELEASE & HIPAA CONSENT**
Effective February 21, 2014

**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 and prior to any service being provided to you by the practice. The Versailles Family Medicine reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer or by asking the provider's receptionist.

**By signing this form**, you acknowledge that you have been given the opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by this Practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and 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 (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH).

**I authorize Physicians/staff of Versailles Family Medicine, to release information pertaining to my child's condition and/or care to those individuals listed below:**

| Name | DOB | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

**Versailles Family Medicine may contact _____ (Name) in the following manner: (check all that apply)**

HOME TELEPHONE NO:_____
☐ OK to leave detailed message on answering machine
☐ OK to leave message with call-back number only
☐ OK to leave detailed message with family member
Who?_____

WORK TELEPHONE NO:_____
☐ OK to leave message on voicemail with detailed message
☐ OK to leave message with call-back number only
☐ OK to leave message with co-worker
Who? _____

CELLULAR TELEPHONE NO: _____
☐ OK to leave detailed message on voicemail with detailed message
☐ OK to leave message with call-back number only

WRITTEN COMMUNICATION
☐ OK to mail to my home address
☐ OK to mail to my work/office address
☐ OK to fax to this number_____
☐ OK to email to the following email address:
_____

I have read and understood the Versailles Family Medicine Notice of Privacy Practices (Privacy Policy) and understand/authorize this consent form by signing below.

Patient Name: _____ DOB:_____

Signature of Patient/Legal Representative:_____ Date: _____

If Legal Representative, relationship to Patient: _____

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# Authorization to Release Patient Identifiable Health Information

Patient Name:_____ Social Security Number:_____
Patient Address:_____ Phone:_____
City, State, Zip Code:_____ Date of Birth:_____

I, _____, herby authorize Versailles Family Medicine, PLLC to receive or disclose my protected health information described below to/from: _____ (Name)

_____ (Address)

The purpose for requesting this release of information is (check one):

- ☐ at the request of the individual
- ☐ other (please describe) _____

This authorization for use and/or disclosure applies to the information described below:

- ☐ Complete Medical Records
- ☐ Any and all records in the possession of Versailles Family Medicine, PLLC including mental health, HIV and/or substance abuse records (Cross out any item you do not authorize to be released)
- ☐ Records regarding treatment for the following condition of injury: _____
- ☐ Records covering the period of time _____ to _____
- ☐ Other (please specify – includes dates) _____

This is the minimum amount of information necessary for the purpose described above. No other information will be disclosed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Versailles Family Medicine, PLLC., 360 Amsden Avenue, Suite 504, Versailles, KY 40383. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that Versailles Family Medicine, PLLC may not condition my treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires one (1) year from the date of signature unless a specific date or event is listed:_____

I certify that I have received a copy of this authorization. I understand that this request must be filled out entirely to ensure timely release of my information.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Witness