Community Family Clinic, PLLC

Revised Feb 2022

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 Community Family Clinic 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 Community Family Clinic, PLLC 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 Community Family Clinic, PLLC. In addition, I give permission for the following person(s) to bring my child to CFC 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 CFC will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing, CFC 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 Community Family Clinic, PLLC, we are committed to protecting the security and privacy of your child's personal information. Medical records are the property of CFC, 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 Community Family Clinic, PLLC.
- I understand that CFC may call my home and place of employment for health care reasons, appointment reminders and to resolve bill issues.
- I understand that CFC may fax immunization certificates, school excuses, physical/sports forms and /or medication instructions to my personal or work fax, or mail to my home. CFC cannot fax or send these documents to third parties without my permission.
- I understand that CFC my leave messages on my answering machine and/or voicemail regarding appointments and limited lab information.
- I understand that CFC 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 Community Family Clinic, PLLC'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: _______________________________ Signature: _______________________________ Date:_____________

Witness

Printed Witness Name: _______________________________ Signature: _______________________________ Date:_____________

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.

- **INSURANCE** – 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 regardless of the type of appointment. This arrangement is part of your contract with your insurance company. This includes, but not limited to:
  - Visits held inside the office.
  - Visits held outside the office (Ex: sick visits conducted in Parking Lot)
  - Telehealth Visits - Doxy.Me, Facetime, Facebook Messenger, Phone Visits, etc.
- **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, American Express and MasterCard (credit and debit).**
- **A $25 fee will be charged for any check returned for insufficient funds.**

COVID BILLING POLICY

If the only reason for your visit is to be COVID-19 tested, please note that your insurance will be billed for both the lab (if applicable) and an office visit as you will be seen by a Provider. You will be responsible for any Co-pay and Deductibles that may apply.

- *NOTICE:* If the facilities current COVID-19 testing is state funded your insurance company ***will not*** be billed for the lab/test. However, if the facilities COVID-19 testing stock has been purchased by the practice, then your insurance ***will*** be billed for the lab/test.

BILLING POLICY

Community Family Clinic, PLLC 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 Community Family Clinic, PLLC to treat any necessary information to process such claims.

Printed Name: ____ Date: __________________________

Signature: ____

10 OFFICE POLICY

Thank you for choosing Community Family Clinic, PLLC 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.

Cancelation / No Show Policy

Our goal is to provide quality individualized care in a timely manner. Late cancelations and No Shows (includes arriving more than 15 minutes late) create inconvenience and prevent scheduling of other patients who need access to care in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advance notice within 24 hours when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

As a courtesy and to help patients remember their scheduled appointments, Community Family Clinic, PLLC will send reminder calls 3 days, then 2 days in advance of the appointment.

Walk-In Policy

Depending on patient load, CFC 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.

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- I have received a copy of the HIPAA Privacy Notice from Community Family Clinic, PLLC.
- I understand that CFC may call my home and place of employment for health care reasons, appointment reminders and to resolve billing issues.
- I understand that CFC 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. CFC cannot fax or send these documents to third parties without my permission.
- I understand that CFC may leave messages on my answering machine and/or voicemail regarding appointments and limited lab information.
- I understand that CFC 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 ____

2. TO DISCLOSE THE HEALTH INFORMATION, AS DESCRIBED BELOW, OF THE ABOVE-NAMED PATIENT TO: **COMMUNITY FAMILY CLINIC, PLLC**

   □ 784 HWY 36 FRENCHBURG, KENTUCKY 40322 PHONE: (606) 768-9190 FAX: (606) 768-6249

   □ 125 FOXGLOVE DRIVE, SUITE D MT. STERLING, KENTUCKY 40353 PHONE: (859) 498-3333 FAX: (859) 498-3332

   □ 17 MILLER DRIVE OWINGSVILLE, KENTUCKY 40360 PHONE: (606) 674-3033 FAX: (606) 674- 3036

   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	YES	NO	INFORMATION AUTHORIZED TO RELEASE	INITIALS
		MAJOR EVALUATIONS				ORDER & PROGRESS NOTES	
		TREATMENT PLANS				DISCHARGE SUMMARIES	
		APPOINTMENT HISTORY				LABORATORY RESULTS	
		OFFICE NOTES				RADIOLOGY RESULTS	
		HISTORY & PHYSICAL				PATHOLOGY REPORTS	
		CONSULTATION NOTES				EMERGENCY ROOM RECORD	
		ADDICTION TREATMENT				OPERATIVE REPORTS	
		URINE DRUG SCREENS				NURSE NOTES	
		MEDICATIONS				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

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

COMMUNITY FAMILY CLINIC, PLLC

POLICY AND OPERATIONAL STANDARDS – TELEMEDICINE INFORMED CONSENT FORM

PATIENT INFORMATION	
Patient Name:	DOB:
Provider Location: Community Family Clinic, PLLC (Frenchburg, Mt. Sterling, Owingsville)	
Consulting Provider Name Seeing Patient via Telehealth: All Providers employed by Community Family Clinic, PLLC	

INTRODUCTION

You are going to have a clinical visit using videoconferencing technology which consists of two-way video and audio. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. In some cases, your visit may consist of a telephone call between you and your Provider. Since 1994, technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconference technology or by phone, you may reject the use of technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, which may which may require additional in-person visits.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. You will be promptly notified of any security issues arise.

By Signing this Form, I understand the following:

1. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care treatment.
2. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may at any time stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand that technology problems may necessitate an in-person visit with the provider.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
4. I understand that other's may be present during my telehealth visit (ie: staff operating/assisting with telehealth equipment) and it is my right to ask for any other non-clinical personnel to leave the telehealth exam area.
5. I understand that if Community Family Clinic, PLLC is not my Primary Care Physician, any record obtained during my visit will be sent to my specified PCP.
6. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
7. I understand that I will be responsible for any copayments or coinsurance that apply to my telemedicine visit.

Patient consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize Community Family Clinic, PLLC to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or authorized person) ____ Date ________________________

If authorized signer, relationship to the patient ____

Witness ____ Date ________________________