



**MERCY MEDICAL ASSOCIATES – KY
PATIENT REGISTRATION**

Date: _____

Patient Name: _____

Home Street Address: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Emergency Contact Phone Number: _____

Emergency Contact Name: _____ **Relationship:** _____

Fax Number: _____

E-Mail Address: _____

Date of Birth: _____

Social Security Number: _____

Sex: Male / Female **Marital Status:** _____

Employer: _____

Employer Address: _____

City: _____ **State:** _____ **Zip:** _____

Spouse Name: _____

Spouse Work Phone Number: _____

Cell Phone Number: _____

May we leave a message regarding confidential health information on the voice mail or answering machines at the numbers provided? Yes / No



**MERCY MEDICAL ASSOCIATES - KY
HISTORY AND PHYSICAL**

Patient Name: _____ Date of Birth: _____

PLEASE READ AND COMPLETE IN FULL. PLEASE LIST ANY ADDITIONAL PERTINENT INFORMATION

Medications:

Allergies:

Referring Physician: _____

Referring Physician Address: _____

Referring Physician Phone Number: _____

Primary Care Physician: _____

Primary Care Physician Address: _____

Primary Care Physician Phone Number: _____

How did you hear about our practice? _____

Chief Complaint:

Area of Complaint/Pain: _____

History of Present Complaint:

Have you ever treated with another physician for this problem? Yes / No

If so, Please list and provide their notes:

Physician: _____

Associated Sypoms: _____

Treatment for this problem: _____

Pain is Aggrevated by: _____

Pain is Relieved by: _____

Social History

Do you use tobacco products? Yes / No If yes: Smoke / Smokeless

Pks/Cans per day: ___ # ___ years or Quit # ___ years / months / days ago.

Do you drink alcohol? Yes / No Daily / Occasionally / Rarely

Do you use recreational drugs? Yes / No Please List: _____

Have you ever used needles to inject drugs? Yes / No

Are you or have you ever taken Coumadin (Warfarin) or Plavix? Yes / No When? _____

Caffeine Intake: None Coffee/Tea/Soda _____ cups per day

Employed: Yes / No Type of Work: _____

Current Grade Level: _____ Highest Education Completed: _____

Have you considered harming yourself to escape your pain? Yes / No

Have you planned a suicide attempt? Yes / No

Have you attempted suicide in the past? Yes / No

Has a close friend or family member committed suicide? Yes / No

Past Medical History:

___ Alcohol or Drug Abuse _____ ___ Heart Trouble _____

___ Arthritis _____ ___ Hepatitis _____

___ Blood Clots _____ ___ High Blood Pressure _____

___ Cancer _____ ___ Kidney Problems _____

___ Diabetes _____ ___ Psychiatric Problems _____

___ Emphysema _____ ___ Stroke _____

___ Varicose Veins _____ ___ Vascular disease _____

___ High Cholesterol _____ ___ Blood Clots _____

___ Carotid disease _____ ___ Cancer _____

___ Other _____

Are your immunizations current? Yes / No Immunizations Needed: _____

Date of Last physical: _____

Family Medical History (Please **check** and list completely all pertinent family medical history)

M-Mother F-Father B-Brother S-Sister C-Child G-Grandparent A-Aunt U-Uncle CS-Cousin

___ Bleeding Trouble _____

___ Heart Attacks _____

___ Cancer _____

___ High Blood Pressure _____

___ Colitis _____

___ Kidney Disease _____

___ Diabetes _____

___ Tuberculosis _____

___ Seizures/Epilepsy _____

___ Ulcers _____

___ Other _____

Are you Currently experiencing any of the following Symptoms or Problems?

- | | | | | |
|---------------|----------------|---------------|-------------------|-------------------------|
| Fever | Chills | Fatigue | Night Sweats | Change in Appetite |
| Weight Gain | Weight Loss | Headaches | Vision Changes | Change in Sleep |
| Vertigo | Nose Bleeds | Sinus Pain | Loss of Smell | Difficulty Swallowing |
| Pain | Chest Pain | Hypertension | Heart Disease | Limitation of Motion |
| Palpitations | Asthma | COPD | Tuberculosis | Shortness of Breath |
| Constipation | Liver Trouble | Incontinence | Stomach Ulcers | Irritable Bowel Syndrom |
| STDs | Blood in Urine | Weakness | Arthritis | Erectile Dysfunction |
| Muscle Pain | Lesions | Neurofibromas | Rashes | Irregular Periods |
| Shingles | Confusion | Mini Strokes | Seizures | Numbness/Tingling |
| Depression | Anxiety | Diabetes | Suicidal Thoughts | Bipolar Disorder |
| Blood Clots | Anemia | MRSA | Thyroid Condition | Excessive Urination |
| Hepatitis B/C | AIDS/HIP | Lumps | Excessive Thurst | Excessive Bruising |
| Swelling | Stress | Heartburn | Blood Stool/Urine | Connective Tissue Dis. |

Other: _____

Past Surgical/Medical History

__ Heart Cath Date: _____ Lab Work Date: _____

__ Chest X-ray Date: _____ Pulmonary Function Test Date: _____

__ MRI of _____ Date: _____

__ CT Scan of _____ Date: _____

__ Bone Scan of _____ Date: _____

__ Plain X-ray of _____ Date: _____

__ Bone Density Test Date: _____ Ultrasound Date: _____

__ Pap Smear Date: _____ Prostate Exam Date: _____

__ Mammogram Date: _____ Hysterectomy Date: _____

__ Tubial Ligation Date: _____ DNC Date: _____

__ Pregnancies # _____ # Deliveries _____ # Miscarriages _____

Abortions _____ Do you still have menstrual periods? Yes / No

Last Menstrual period: _____ Breast Self Exams: Yes / No

__ Back Surgery Date: _____ Type: _____

__ Neck Surgery Date: _____ Type: _____

__ Joint Replacement Date: _____ Type: _____

__ Other Surgeries/Dates: _____

All of the responses given on my history and physical form are complete and correct to the best of my knowledge. I understand they will be considered the official history and physical portion of my medical records.

Signature

Date

Relationship if other than patient



**MERCY MEDICAL ASSOCIATES – KY
MEDICAL RECORDS RELEASE**

Date: _____

Patient's Name: _____

Date of Birth: _____

I, _____, request that
Patient's Name

Physician's Name

Physician's Street/Mailing Address

Physician's City, State, Zip

Physician's Phone number

Physician's Fax number

release all medical records including, but not limited to office notes, operative notes, history and physical notes, referring consultant notes, lab work, x-rays, x-ray readings, physical therapy notes, medication notes to:

Physician's Name

Physician's Street/Mailing Address

Physician's City, State, Zip

Physician's Phone number

Physician's Fax number

Signature of Patient/Guardian

Date



**MERCY MEDICAL ASSOCIATES – KY
PATIENT INSURANCE INFORMATION**

Date: _____

Patient Name: _____

Date of Birth: _____

Primary Insurance: _____

Insurance Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Subscribers Name: _____ **Relationship to Patient:** _____

Insured's Date of Birth: _____ **Group Number:** _____

Subscriber ID Number: _____ **SS# of Insured:** _____

Co-pay Amount: _____ **Deductible:** _____

Secondary Insurance: _____

Insurance Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Subscribers Name: _____ **Relationship to Patient:** _____

Insured's Date of Birth: _____ **Group Number:** _____

Subscriber ID Number: _____ **SS# of Insured:** _____

Co-pay Amount: _____ **Deductible:** _____

Were you involved in a motor vehicle accident? Yes / No

Were you involved in an accident at work? Yes / No

Were you involved in any other type of accident? Yes / No

Have you applied for Social Security Disability? Yes / No

Have you applied for state medical assistance? Yes / No

Have you applied for financial assistance from any other source? Yes / No



**MERCY MEDICAL ASSOCIATES – KY
INSURANCE SIGNATURE PAGE**

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

The insurance information I have provided is correct to the best of my knowledge. I understand that my insurance policy is a contract between myself and the insurance company. I understand that co-pays and deductibles are due at the time services are rendered and agree to pay these unless prior payment arrangements have been made. I authorize the release of any health information, including diagnosis and the records of any treatment of examination rendered to me during the period of such care to my insurance company and/or other healthcare practitioners. I also authorize any practice or provider of Mercy Medical Associates – Ky to receive any medical, osteopathic or chiropractic physician, hospital, clinic, rehabilitation facility, or other medical practitioner or provider’s medical information that has or is or will be furnishing services to me. I authorize and request my insurance company to pay directly to the providers, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for payment of all services rendered on my behalf regardless of my insurance coverage. In the event of default or if bill must be referred to a collection agency or attorney for collection, I will agree to pay court costs and reasonable attorney fees if suit is filed to recover my account. I authorize any practice or provider of Mercy Medical Associates – Ky to release to my worker’s compensation company, case manager, motor vehicle insurance company, Social Security Administration and Health Care Financing Administration or its intermediaries or commercial insurance company any and all information pertaining to my care and treatment by phone, fax, mail or in person. I understand that if I have not secured appropriate authorizations and otherwise complied with the terms of my health benefit plan, there may be a decrease in my coverage or no coverage at all for some or all of the services with I receive and that I will be financially responsible for services not covered. I agree that if my provider is out of network with my insurance company that I will be personally and fully responsible for payment. I have read and understand the office financial policies and agree to comply and accept the responsibility for any payment that becomes due as outlined. This authorization will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature

Date

Relationship if other than patient



MERCY MEDICAL ASSOCIATES - KY
HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

If you have any questions, please contact our Privacy Officer, whose name and number is at the bottom of this notice.

Who will follow this notice?

Lourdes provides health care to our patients, residents and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional who treats you at any of our locations.
- All departments and units of our organization, including Lourdes HomeCare, Lourdes Hospice, Lourdes Wound Care Center, Lourdes Transitional Care Unit, Lourdes Home Infusion, Lourdes Diabetes Center, Lourdes Medical Staff.
- All employed associates, staff or volunteers of our organization, including staff at Lourdes, our regional office and Catholic Healthcare Partners, our parent organization, with whom we may share information.
- Any business associate or partner of Lourdes, with whom we share health information.

Our pledge to you

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- keep medical information about you private,
- give you this notice of our legal duties and privacy practices with respect to medical information about you,
- follow the terms of the notice that is currently in effect.

Changes to this Notice

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, exam rooms, and on our Web site at www.lourdes-pad.org. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our facility for treatment. You will also be asked to acknowledge, in writing, your receipt of this notice.

How we may use and disclose medical information about you

- We may use and disclose medical information about you for **treatment** (such as sending medical information about you to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as comparing patient data to improve treatment methods).
- We may use or disclose medical information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies**. We also disclose medical information **when required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

- We also may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you, or to support **fundraising efforts**.

- If admitted as a patient, unless you tell us otherwise, we will list **in the patient directory**, your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to a clergy member, and even if they do not ask for you by name.

- We may disclose medical information about you to a **friend or family member who is involved in your medical care**, or to disaster relief authorities so your family can be notified of your location and condition.

Other use of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

- In most cases, **you have the right to look at or get a copy of medical information** that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your record is incorrect or if important information is missing, **you have the right to request that we correct the records**, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.

- **You have the right to a list of those instances where we have disclosed medical information about you**, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

- If this notice was sent to you electronically, **you have the right to a paper copy of this notice**.

- **You have the right to request that medical information about you be communicated to you in a confidential manner**, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

- **You may request, in writing, that we not use or disclose medical information about you** for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request **but we are not legally required to accept it**. We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Officer, listed at the bottom of this notice.

Complaints

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer. You may also contact our Corporate Responsibility Officer at (270)444-2779 or the Catholic Healthcare Partners Report Line, a 24-hour hotline, at 1-888-302-9224.

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer: Natalie Reynolds (270)444-2479 (270)444-2137 (fax)
Lourdes Hospital 1530 Lone Oak Road Paducah, KY 42003



**MERCY MEDICAL ASSOCIATES -KY
PATIENT CONSENT TO USE & DISCLOSE HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

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

I understand that as part of my health care, Mercy Medical Associates –Ky, their practices and providers, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among my other health care professionals
- A source of information for submitting medical claims for payment
- A means by which a payer can verify rendered

I understand and have been given a *Notice of Privacy Practice* that provides a more complete description of health information uses and disclosures, as well as my rights regarding the use and disclosure of my health information.

I understand that Mercy Medical Associates – Ky, their practices and providers, is not required to agree to any restrictions requested and I may revoke this consent in writing. Such revocation will not apply to authorized uses and disclosures made prior to the revocation.

I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me as permitted by Section 164.506 of the *Code of Federal Regulations*.

I understand Mercy Medical Associates – KY, their practices and providers reserve the right to change the notice and practices prior to implementation in accordance with Section 164.520 of the *Code of Regulations*. Should the notice be changed, the practice will send a copy of any revised notice to the mailing address I have provided.

I understand health information may be used or disclosed by mail, telephone, electronic means, and by fax. I authorize the use or disclosure of my health information for purposes of treatment, payment, or healthcare operations to other health care professionals involved in my care/treatment, insurance, third-party payers, pharmacies, and the following relative(s) and/or others:

Name Relationship

Name Relationship

Name Relationship

I wish to have the following restrictions placed on the use and disclosure of my health information:

I fully understand and **accept** the terms of the consent:

Patient's Signature

Date

Relationship if other than patient



MERCY MEDICAL ASSOCIATES - KY
OFFICE FINANCIAL POLICY

Our goal is to maintain and develop strong relationships between our physicians and patients through good communication. Sharing these office financial policies in advance should help you maximize your insurance coverage and help prepare you for requirements in making appointments, payments, and referrals. We hope that making you aware of our office policy in advance helps you clearly understand your responsibilities as we work with you to address your health needs. Please read this carefully. If you have any questions, do not hesitate to ask a member of our staff.

Insurance Cards

- At every visit, first please sign in and present your current insurance card.
IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND FOR SUBMITTING THE CHARGES TO THE CORRECT PLAN.
- If we are your primary care physician, make sure our name or phone number appears on your card.
- If your insurance company has not been informed that we are your primary care physician as of the date of your office visit, you are responsible for any and all co-payments, deductibles and co-insurances.

Insurance Coverage

It is your responsibility to understand your benefit plan.

- It is your responsibility to know what services are covered, if a written referral or authorization is required to see us as a specialist, and/or if preauthorization is required prior to a procedure.
- Before making an annual physical appointment, please check with your insurance company to see if the visit will be covered as a healthy visit. Not all plans cover annual wellness visits or hearing and vision screenings. If it is not covered, you will be responsible for payment at the time of visit.
- Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
- Advance notice, typically 3 to 5 business days, is needed for all non-emergent referrals. Remember, your primary care physician must approve referrals before being issued. It is your responsibility to know if a selected specialist participates in your plan.

Payments

- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
- If you have no insurance, payment for an office visit is to be paid at the time of the visit.
- Co-payments are due at time of service.
- If you participate with a high deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card to keep on file. In this case, there are addenda to this financial policy which are signed separately.

Fees

- We require 24 hour notice for canceling any appointments. You may be subject to a cancellation fee if a 24-hour notice is not given.
- \$25 plus bank fees will be charged for any returned checks.
- Fees will be charged to fill out forms. (Approximate fee is \$35 per form, but please ask a staff member for definite fee amount.) Payment is due when the forms are dropped off. There is a 3 to 5 day turnaround time for form completion.