Versailles
Family Medicine

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

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

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

Place of Employment:_____ Occupation: _____

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

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

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

Ethnicity: ☐Hispanic ☐Non-Hispanic

Language: ☐English ☐Spanish ☐Other _____

EMERGENCY CONTACT

First Name:_____ MI: _____ Last Name: _____

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

Street Address (if PO Box): _____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

Do you 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:(___)_____

Is this visit related to an auto accident or workers compensation claim? ☐ Yes ☐ No

Date of accident: _____ Claim #:_____ Claim Contact person: _____

Claim billing address: _____ City: _____ State: _____ Zip: _____

THIS INFORMATION MUST BE COMPLETED TO BE SEEN FOR AN ACCIDENT RELATED INJURY!

RESPONSIBLE PARTY

If the above patient is a minor, please indicate their responsible party below.

☐ 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: _____

RELEASE OF INFORMATION

Please list any individuals whom are granted access to obtain any of the patient's medical information:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Do we have your permission:

to leave a message on your home answering machine? _____

to leave a message at your place of employment? _____

PHARMACY INFORMATION

Please indicate your preferred pharmacy below.

Pharmacy Name:_____ Phone Number: _____

Address: _____City: _____ State: ____ Zip: _____

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PATIENT AND FAMILY MEDICAL HISTORY

Disease	Patient	Father	Mother	Paternal Grandparents	Maternal Grandparents	Siblings
*Indicate if deceased	----------					
Alcoholism						
Arthritis						
Asthma						
Bleeding Disorder						
Cancer						
Colon Polyps						
Diabetes						
Epilepsy						
Heart Disease						
High Cholesterol						
Hypertension						
Kidney Disease						
Mental Illness						
Skin Disorder						
Stroke						
Suicide						
Tuberculosis						
Other						

HOSPITALIZATIONS		
Reason for admission	Hospital	Month/Year

OPERATIONS & PROCEDURES	
Name	Month/Year

MEDICATION ALLERGIES	
_____ NO KNOWN ALLERGIES	
MEDICATION NAME	TYPE OF REACTION

CURRENT MEDICATIONS			
NAME	DOSE	TIMES PER DAY	REASON FOR TAKING

SOCIAL HISTORY

Smoking	Yes	No	If so, how long? Packs?	
Smokeless Tobacco	Yes	No	If so, what kind(s)? How long?	
Alcohol	Yes	No	If so, how long?	
Recreational Drug Use	Yes	No	If so, what kind(s)? How long?	
Marital Status	Yes	No	If so, how long?	
Children/Step-children	Yes	No	If so, how many?	
Occupation	Type of work		If so, how long?	
Religious	Yes	No		
Exercise	Yes	No	If so, how much daily?	
Caffeine	Yes	No	If so, how much daily?	
Sexually Active	Yes	No		
Travel outside of US	Yes	No	If so, to where?	
Occupational Exposure	Yes	No		
Smoke Detector	Yes	No		
Pets	Yes	No	If so, how many? What kinds?	

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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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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 condition and/or care to those individuals listed below:

Name	DOB	Relationship

Versailles Family Medicine physicians/staff may contact me 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

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)