River Cities Bone and Joint Centre

Joseph R. Leith, M.D.
1000 Ashland Drive, Suite 103
Ashland , Kentucky 41101
606-324-0097

PATIENT INFORMATION – PLEASE PRINT

PATIENT NAME:____

SOCIAL SECURITY NUMBER;____________________DATE OF BIRTH:__________

MARITAL STATUS S M W D SEX M / F

MAILING ADDRESS:____

CITY:______________________ STATE:__________ ZIP CODE:________

HOME PH:_______________________ CELL PH:____________________

EMPLOYER:____________________OCCUPATION:___________________

EMAIL ADDRESS:____

EMERGENCY CONTACT_______________________ PHONE #__________

WORK RELATED? Y / N IF YES, DATE OF INJURY:__________ CLAIM#__________

AUTO ACCIDENT? Y / N IF YES, DATE:__________ CLAIM INFO:______________

PRIMARY INSURANCE:____

SUBSCRIBER NAME:____

SUBSCRIBER BIRTHDATE:____________________ SS#__________________

SECONDARY INSURANCE:_______________________________________

SUBSCRIBER NAME:__________________ SUBSCRIBER BIRTHDATE__________

SPOUSE / PARENT NAME_______________________________________

ADDRESS (IF DIFFERENT FROM ABOVE)___________________________

PRIMARY CARE PHYSICIAN:____________________________________

PHARMACY____

River Cities Bone & Joint Centre
Joseph R. Leith, M.D.

AUTHORIZATION OF PERSONAL REPRESENTATIVE TO RECEIVE PROTECTED HEALTH INFORMATION

You may rely upon your spouse, relatives or friends from time to time to understand your treatment options, visit your physicians, acquire prescriptions, get test results, and otherwise be involved in your medical care. However, federal law does not allow us to Disclose any of this information to these people unless you appoint them as your "personal representatives".

To appoint an Individual as your personal representative, complete this form.

I hereby authorize River Cities Bone & Joint Centre to release the following protected health information to the Individual I have designated:

Name	**Relationship** Spouse, Relative, Friend, Other

I may revoke this authorization at any time. My revocation will NOT affect any actions that have been already taken in reliance on my original authorization.

____
Patients Printed Name Date

____
Patient's Signature

____
Signature of Patient Representative Relationship

River Cities Bone and Joint Centre

PRESCRIPTION POLICY

The purpose of this agreement is to prevent misunderstandings about certain medicines you may be taking for pain management. This is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

- I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this agreement
- **I understand that if I break this agreement, my provider will discontinue prescribing me any or all medications**
- I will not use any illegal substances, including Marijuana, cocaine, etc.
- I will not share, sell, or trade my prescribed medications with anyone.
- I will not attempt to obtain any prescriptions, including Opioid pain medicines, controlled stimulants, or anxiety medications from any other source, ***including the ER***, unless I discuss it first with my provider.
- I will safeguard my medication from loss or theft. Lost or stolen medication will not be replaced.
- I understand that medication refills are made **only** during regular business hours, and according to my pain medication schedule given at the time of surgery with **NO EXCEPTIONS**.
- I understand that controlled substances may have adverse side effects such as but not limited to drowsiness. Any questions, concerns and precautions I may need to take I understand I will need to speak to my local pharmacist about. Each prescription comes with a list of side effects and I accept the responsibility to read them carefully.
- I agree to use ______________________________ Pharmacy,
- located ____,
- Telephone Number______________________________, for filling my prescriptions for **ALL OF MY PAIN MEDICATION.**
- I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency.
- Kentucky law requires our office to obtain a KASPER report prior to prescribing any and all controlled substances. **I understand once the report is obtained, if the report indicates I am being prescribed a controlled substance from any other provider Dr. Leith will NOT prescribe me any further medication.**

This agreement is entered into by:

____

Patient / Representative Signature **Date**

Acknowledgement of Office and Financial Policies

I acknowledge that by signing below I have received, read, and understand River Cities Bone and Joint Centre Office and Financial Policies.

Patient (Guardian) Signature: ______________________________

Patient (Guardian) Printed Name: ______________________________

Date: ______________________________

River Cities Bone and Joint Centre Office and Financial Policies

We would like to thank you for choosing River Cities Bone and Joint Centre as your medical provider. As our patient we would like to keep you informed of our current office and financial policies. We ask that you read and sign the attached document prior to treatment. Please keep this document for future reference.

Cancelled Appointments: If you are unable to keep your appointment please call our office at least 24 hours before your scheduled appointment time to cancel or re-schedule. This will allow us time to schedule patients who are currently waiting for an appointment If you do not call 24 hours prior to your appointment, you may be subject to a $50.00 no-show appointment fee. Any no-show fees must be paid prior to your next office visit.

Prescription Requests: Please note that prescriptions are not refilled after regular business hours, on weekends or holidays. Prescription refill requests require 24-48 hour notice for all refills and prescription requests. ALL prescription requests must be made via the prescription request line at extension **27.** We do not accept or take walk in requests for prescriptions. Regular business hours are 7:00am-3:30pm Monday-Thursday and 7:OOam-12:OOpm Friday. If you are picking up narcotic prescriptions we will require a valid ID, if someone is picking it up for you, they must be on your record as authorized by you in writing and will be required to present a valid ID. *Pain medication refills will only be available per the schedule provided at the time of surgery with no exceptions.*

Uninsured Patients: We offer a discounted rate to all self-pay patients. If you are a self- pay patient, we require you have available at least $200.00 in order to schedule an appointment, payable at time of service. Your actual bill may be more or less than this amount, as charges vary based on treatment. You will receive an itemized statement of your charges at your appointment Any remaining balance, should there be one, must be paid in full within 30 days or before any follow-up appointment, whichever is first.

Insurance: Patients are required to present a current Insurance ID card and photo ID at the time of appointment, and to notify the front office staff of any changes to coverage. All co-pays are required at check-in. If you are unable to pay the contracted co-pay amount, you may be asked to reschedule. This **arrangement is part of your contract with your insurance company.** Failure on our part to collect co-payments and deductibles from patients can be considered fraud. In addition, you may be responsible for any co-insurance, deductible amount, or non-covered services not paid by your insurance within the state's required time limitation for paying healthcare claims. You will receive a statement from our office indicating what your insurance has paid; this should match the Explanation of Benefits your carrier provides you. Any remaining balance is due upon receipt. Contact our billing department if you have any questions. **It is imperative that we bill the correct insurance company for your services; providing the incorrect information to us will delay correct filing of claims and may result in the services being the patient's financial responsibility.**

River Cities Bone and Joint Centre Office and Financial Policies ____

Auto Insurance: We do not bill auto insurance. We collect $200.00 up front at check-in and you will be considered as self-pay and any charges for the visit will be collected in full at check-out. If an attorney is involved we need his/her name on file, as well as a release to send medical records to them as requested. It is our policy to collect your private insurance information at the time of your first appointment, this will only be billed in the event you notify us that your PIP is exhausted, and we will submit a copy of the exhaustion letter to the Auto Insurance Company.

Worker's Compensation: If your injury is work related, please be sure to contact your employer and inform them of your injury. Before we can schedule your appointment we will need your BWC MCO to authorize your initial visit. We will also need your Claim Number, Date of Injury, any allowed diagnosis, and billing information. Failure to report your injury to your employer properly may result in the denial of your claim; **denied claims will become Patient** Responsibility **and will be due** in full at the **time** of denial. We will not see any new patients with a Worker's Compensation claim older than 6 months.

Returned Checks: A $30.00 charge will be added to your account for any checks returned by your bank for any reason. All returned check fees, as well as any resulting outstanding balances must be paid in full prior to scheduling your next appointment.

Disability, Work, Family, **and Medical Leave Forms:** There will be a charge of $25.00 per document for the completion of any of these forms. Payment is required when forms are presented, prior to their completion. Once received, RCBJ will have 14 business days to complete these forms. Please call the front office to arrange pick up of these records if you haven't been notified they are ready.

Medical Records: We will provide you with one free copy of your medical records upon request. You will need to sign a letter of release at the time of pick up. Please allow 7 —10 business days for us to complete your request. If you require additional copies of your records, per KRS 422.317 you will be charged a fee of $1.00 per page payable at the time of request.

X-Rays: We will provide you with a copy of your X-rays on a CD upon request. You will need to sign a letter of release, and pay the fee of $10.00 when your request is submitted. Please allow two business days to complete this request

Surgery Sign-Up: Our billing department will authorize your benefits, and obtain any necessary prior authorizations from your insurance company; it is your responsibility to verify this information is correct to avoid patient financial responsibility. Our billing staff will provide you with an estimated patient responsibility which we will collect prior to your surgery time being assigned. All prior balances must also be paid in full before surgery is scheduled. We participate with Care Credit financing to ensure patients have flexible payment options available when needed.

If you have any questions or concerns, please contact our office at 606-324-0097.
Thank you for the opportunity to serve you.

Acknowledgement of Office and Financial Policies

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Joseph R. Leith, M.D., P.S.C. reserves the right to modify the privacy practices out-lined in the notice. By signing below I acknowledge I have received a copy of the Notice of Privacy Practices for Joseph R. Leith, M.D., P.S.C.

____

Name of Patient

____

Signature of Patient Date

____

Signature of Patient Representative Relationship

River Cities Bone and Joint Centre

Medical History Form

Patient Name: ______________________ DOB: ____________ Age: ________

Dominant Hand: ☐ R ☐ L Height: __________ Weight: __________

Gender ☐ Male ☐ Female

What body part is involved? (Please mark ONLY ONE on the table below)

Shoulder	Elbow	Wrist	Hand	Hip
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ l	☐ R ☐ L
Knee	**Ankle**	**Foot**	**Neck**	**Back**
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ l	☐ R ☐ L

*What test/ scans have you had for this problem? ☐ X-Ray ☐ MRI ☐ CATscan ☐ Bone Scan ☐ Nerve Test

Where? ______________________

In this section, check the ONE BOX that describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ NO INJURY (or onset was) ☐ Gradual ☐ Sudden

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years

Please indicate why you think it started.

☐ INJURY ☐ Accident ☐ Sport (NOT Auto or Work)

Date: __________ Please specify where and how it happened.

What Sport? __________ School? __________

☐ INJURY AT WORK Date: __________

From a: ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach

☐ WORK RELATED (BUT NO INJURY)

Date: __________ How did your job cause the problem?

☐ AUTO ACCIDENT

Date: How was your car hit?

Comments: ______________________

On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 8 9 10

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent).

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching ☐ Giving Away ☐ Loss of control of bowel or bladder

Since my problem started it is: ☐ Better ☐ Worse ☐ Unchanged

Which make your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Other

Which makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Sitting ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sneezing ☐ Coughing

Were you seen in the E.R for this problem? ☐ Y ☐ N Which E.R? __________ Date: __________

Have you had any of these treatments? Injection: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N

Brace/Cast: ☐ Y ☐ N

Have you had a prior problem or surgery in this same area or issue either recently or in the past? Y ☐ N ☐

If so, please explain: Procedure: ____________________ Surgeon: ____________________

City: ____________________ Date: ____________________

Do your other joints have: ☐ Morning stiffness lasting over 30 minutes ☐ Joint pain or swelling

☐ Gout ☐ Back Pain ☐ Rheumatoid Arthritis ☐ Osteoporosis

☐ Prior Fracture (Which bone?) ____________ ☐ None of these

Patient Medical History

Please check all that apply:

AIDS/HIV ☐	ALCHOLISM ☐	ANEMIA ☐	ASTHMA ☐
BLOD CLOTS ☐	COPD ☐	CROHN'S DISEASE ☐	DEPRESSION ☐
DRUG ABUSE ☐	FIBROMYALGIA ☐	GOUT ☐	HEART DISEASE ☐
HYPERTENSION ☐	KIDNEY DISEASE ☐	MIGRANE HEADACHES ☐	THYROID DISEASE ☐
OSTEOARTHRITIS ☐	PARKINSON DISEASE ☐	RHEUMATOID ARTHRITIS ☐	SEZURES ☐
ULCERS ☐	DIABETES ☐	CANCER ☐ (TYPE?) ____________	

Medications

Allergies to Medications? Y ☐ N ☐

If so, please list allergies and describe reaction:

____

____

What medications are you taking now?

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Medication Name: ____________________ Dosage: __________ Frequency: __________

Past Medical History

Are you diabetic? Y ☐ N ☐ If so, treatment: ☐ Insulin ☐ Oral Medicine ☐ Diet

Are you taking or have you ever taken, blood thinners? Y ☐ N ☐ If so, which ones? ____________________

Have you ever had: ☐ Heart Attack (Year?) __________ ☐ High Blood Pressure

☐ Blood Clots (Year?) __________ ☐ Stroke ☐ Heart Failure

☐ Ankle Swelling ☐ Kidney Failure

Past Surgical History

What operations have you had and when? Please list:

____
____
____
____
____

Family History

Have any direct relatives had any of the following disorders? If so which relative?

	Mother	Father		Mother	Father
AIDS/HIV	☐	☐	CANCER (TYPE:__________)	☐	☐
ALCOHOLISM	☐	☐	COPD	☐	☐
ALZHEIMER'S	☐	☐	CROHN'S DISEASE	☐	☐
ANEMIA	☐	☐	DEPRESSION	☐	☐
ASTHMA	☐	☐	DRUG ABUSE	☐	☐
BLOOD CLOTS	☐	☐	FIBROMYALGIA	☐	☐
GOUT	☐	☐	HEART DISEASE	☐	☐
HYPERTENSION	☐	☐	HEPATITIS	☐	☐
KIDNEY DISEASE	☐	☐	MIGRANE HEADACHES	☐	☐
OSTEOARTHRITIS	☐	☐	PARKINSON DISEASE	☐	☐
RHEUM. ARTHRITIS	☐	☐	SEIZURES	☐	☐
THYROID DISEASE	☐	☐	ULCERS	☐	☐
DIABETES	☐	☐	OTHER (_______)	☐	☐

Social History

Do you use tobacco? Y ☐ N ☐ If so, Type?: ______________________ How much?__________________

Do you smoke? Y ☐ N ☐ If so, how many packs a day: ______________________

Do you use Alcohol? Y ☐ N ☐ If so, how often? ☐ Daily ☐ Other_____/week ☐ Social

Do you use caffeine? Y ☐ N ☐ If so, Type? ______________________________

Current work status? ☐ Regular ☐ Light Duty

☐ Disabled ☐ Retired ☐ Student

☐ Not working due to this problem (When is the last date you worked your regular job?) ____________________

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Patient Signature: ______________________________ Date: ________________

Parent/Guardian: ______________________________ Date: ________________