PATIENT REGISTRATION FORM

Today's Date_____

PATIENT INFORMATION			
Patient's Name: (Please Print Last, First, Middle)	[ ] Mr. [ ] Mrs. [ ] Miss [ ] Miss	Marital Status {circle}: Single/ Married/ Divorced/ Sep/ Widow	
Is this your legal name? [ ] Yes [ ] No	If not, what is your legal name?	Birthdate: / /	Age: Sex: M / F
Street or Mailing Address: {circle}:	City, State and Zip Code:	Home Phone Number: ( )	
Cell Phone Number: ( )	E-Mail Address: (To be used for appointment reminders)	Social Security Number:	
Occupation: (indicate if student)	Employer	Employer Phone Number:	

Employment Status: [ ] 1 – Full-time [ ] 2 – Part-time [ ] 3 – Not Employed [ ] 4 – Self-Employed [ ] 5 – Retired [ ] 6 – Active Military

Student Status: [ ] F – Full-Time Student [ ] P – Part-time Student [ ] N – Not a Student

Race: [ ] American Indian/Alaska Native [ ] Asian [ ] Native Hawaiian/Pacific Islander [ ] Black/African American [ ] White [ ] Hispanic [ ] Other [ ] Declined

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined

Language: [ ] English [ ] Spanish [ ] Indian [ ] Japanese [ ] Chinese [ ] Korean [ ] French [ ] German [ ] Russian [ ] Other_____

Pharmacy:	Do you have a living will? [ ] YES [ ] NO

Referred By: (Please check one box)

[ ] Dr._____ [ ] Insurance [ ] Hospital [ ] Family [ ] Friend [ ] Yellow Pages [ ] Other_____

Other Family Members Seen Here:

PCP Name: Phone Number:

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)		
Responsible Party: [ ] Another Patient [ ] Guarantor [ ] Self	[ ] Check here if information is same as patient	
Name:	Address:	Home Phone Number: ( )
Birth Date:	E-Mail Address:	Occupation:
Employer:	Employer Address:	Employer Phone Number:

INSURANCE INFORMATION (provide your insurance card to the front desk)

Is this visit for one of the following? [ ] WORKERS COMPENSATION (WC) [ ] OCCUPATIONAL MEDICINE (OM) [ ] MOTOR VEHICLE ACCIDENT (MVA)

[ ] ACCIDENT DATE: _____

Does the patient have healthcare coverage? [ ] YES [ ] NO			**Insurance Name:**		
Policy holder's Name:	Social Security Number:	Birth Date: / /	Effective Date: / /	Group ID:	Subscriber ID: (Policy Number)

Patient Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other_____

Name of Secondary Insurance:		Policy holder's Name:	Social Security Number:
Birth Date: / /	Effective Date: / /	Group ID:	Subscriber ID: (Policy Number)

Patient Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ] Other_____

EMERGENCY CONTACT

Name:	Relationship to Patient
Home Phone Number: ( )	Other Phone Number: ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials.

I hereby voluntarily consent for treatment which may include routine diagnostic procedures, examination and medical treatment. I hereby authorize the release of information related to bill my insurance. I authorize payment directly to the Provider for his/her services. Even though the practice agrees to bill my insurance company, I understand that I am ultimately financially responsible for any services not covered by this authorization. I understand that I am responsible for providing any information requested from my insurance to enable them to process my insurance claims and agree to obtain any necessary insurance referrals required by my insurance company. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees and copayments regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office personnel.

Patient/Guardian Signature_____ **Date:**_____

Witness: _____

AUBURN COMMUNITY HEALTH CLINIC

Authorization to Disclose Medical Information

I, _____, give permission to The Auburn Community Health Clinic

to discuss any/all of my (**personal/dependent**), _____'s medical
Circle one
information with the following individuals:

Name: _____DOB: ___/___/_____

Address: _____

_____

Phone: (_____)_____-_____

Name: _____DOB: ___/___/_____

Address: _____

_____

Phone: (_____)_____-_____

Name: _____DOB: ___/___/_____

Address: _____

_____

Phone: (_____)_____-_____

Name: _____DOB: ___/___/_____

Address: _____

_____

Phone: (_____)_____-_____

[ ] NONE

Patient/Parent Signature: _____ Date: ___/___/_____

Auburn Community Health Clinic

HIPAA COMPLIANCE PATIENT CONSENT FORM

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 law. You have the right to review our Notice before signing this consent. The terms of our Notice may change; if we change our notice you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you for treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care 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 to your prior consent. The practice provides this from to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the notice of privacy practices.
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice may not condition receipt of treatment upon the execution of this consent.

This consent was signed by _____
Printed Name of Patient or Representative

_____ _____
Signature Date

Relationship to Patient (if other than patient) _____

Witness _____
Printed Name- Practice Representative

Witness _____ _____
Signature Date

AUBURN COMMUNITY HEALTH CLINIC

Consent to Obtain External Prescription History

- I authorize Auburn Community Health Clinic to view my child's external prescription history via the Rx Hub service.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Parent Signature: _____ Date: ___/___/_____

Consent to Treat

Parent or legal guardian consent must be provided for treatment of a child under the age of 18 for every visit. We understand there are times that it may not be possible for you, the parent, to accompany your child to each visit. Therefore, we will accept a signed consent to treat from the parent or legal guardian for any visit. Written consent must specify the name of the person (adult over 18) granted authorization to bring the child in for treatment. ***As physicians, we PREFER that the parent or legal guardian be present for checkups and immunization visits.*** However, if this is not possible, the form below may be used as well, as long as the child is accompanied by an adult over 18 who has been granted consent.

Parent's Name: _____ gives permission to the following persons to bring my child, _____ to AUBURN COMMUNITY HEALTH CLINIC for any treatment by the medical practitioner, which includes immunizations and injections.

Persons with permission to bring my child to the physician:

Name: _____ DOB: ___/___/_____ Phone: (____) _____-_____

Name: _____ DOB: ___/___/_____ Phone: (____) _____-_____

Name: _____ DOB: ___/___/_____ Phone: (____) _____-_____

Name: _____ DOB: ___/___/_____ Phone: (____) _____-_____

Name: _____ DOB: ___/___/_____ Phone: (____) _____-_____

Name: _____ DOB: ___/___/_____ Phone: (____) _____-_____

Parent Signature: _____ Date: ___/___/_____

P/P TITLE: **Narcotic Policy**	**Section:** **Personnel**	**Page:** **1 of 1**
Original Date: 03/29/2011 **Revised Date: 01/30/2013**	**Reviewed By:**	

Purpose: To establish guidelines for providing standards of care and for providing a protocol when prescribing narcotics or "scheduled medications".

1. Auburn Community Health Clinic can and will provide prescriptions for scheduled medications based on the nature of the injury or condition pending the need. These medications will only be provided for a limited time until a referral can be provided to pain management, specialist (i.e. psychiatry), or other physician. Typically this office only provides pain management for acute pain needs and this time frame is generally no longer than 4-6 weeks. A referral to a specialist will be discussed at office visit and appropriate action will be taken to ensure smooth transition for the patient. We will only be responsible for one pain management referral per patient. After the patient has been successfully referred for evaluation or pain management , we will no longer provide any support or medications. Every effort will be made to first place the patient on a nonscheduled medication as pain level permits. Our office and the pharmacy will closely monitor you prescription refills to reduce any excessive refills, abusive or long term management of medications.

2. It is imperative that only one pharmacy be used by the patient for medications. If you feel that you have good reason and must change pharmacies, the patient must notify the office in advance. All pharmacies involved will then be notified of changes. If, at any time, it is discovered that the patient is using more than one pharmacy for the same medication, the medication will be discontinued and in some situations a dismissal from the practice can result.

3. No narcotics or scheduled medications will be refilled by phone message. It is a requirement to see the nurse practitioner to discuss any further needs or medication refills.

4. It is the responsibility of the patient to disclose a present list of medications, any additional medications added since by another physician, nurse practitioner, etc. It is the patients' responsibility to not receive scheduled medications from more than one provider, unless a referral has been made and the patient will no longer be provided or receiving the medications from their primary care. If at any time our office becomes aware of similar prescriptions from other healthcare providers are being obtained then this practice will no longer provide the medications and possible dismissal from the practice may result.

5. We do not keep any narcotic medications in our office.

6. The following guidelines apply to all patients:

   - No early refills will be provided.
   - Store your medications wisely, legally, & safely. Lost or stolen prescriptions will not be rewritten.
   - Medication is prescribed for the patient, do not let others, for any reason, use the medication prescribed.
   - All medications must stay in original labeled medication bottles.
   - Medications are to be taken as prescribed per the directions.
   - Repeated calling for medication refills of narcotics or scheduled medications will not be tolerated and may result in dismissal.

I have read and understand the above policy regarding narcotics and scheduled medications.

Patient's Signature:_____ Date:_____

Providers: Stacia A. Stapleton Date: 01-30-13

Drusha Campbell Date: 01-30-13

Date: 01-30-13

AUBURN COMMUNITY HEALTH CLINIC
128 SUGAR MAPLE DR.
AUBURN, KY 42206
PHONE (270)542-5500 FAX (270)542-5015

AFTER HOURS NUMBERS:
STACIA STAPLES APRN (270) 893-2658
JAMES STAPLES APRN (270) 893-2769
TRISHA CAMPBELL APRN (270) 847-5320

OFFICE HOURS:
MONDAY-FRIDAY 8 AM-5:30 PM
SATURDAYS 8 AM- 4 PM
CLOSED FOR LUNCH 12-1 DAILY

If you need assistance after hours call you may be able to reach the Nurse Practitioners at the above numbers. Please allow a sufficient time for your call to be returned. Please wait until office hours for all non-emergency requests. **If you have a life threatening emergency after office hours, please go to your nearest emergency room or dial 911.**

Effective October 18th, 2010 our office has established specific polices in reference to services rendered by our Nurse Practitioners here at Auburn community Health Clinic. Our office will make every effort to accept walk in appointments for established patients. Appointment times over 15 minutes late may have to be rescheduled for another date and time. Missed appointments are tracked and after an accumulation of 3 missed appointments no further appointments will be rescheduled.

Weather Polices:
In the event of severe weather conditions such as snow, ice or tornadoes, etc., please call our office to verify that the office will be open. If conditions endanger our employees or patient's safety, the office will be closed until weather conditions improve. We will attempt to notify scheduled appointments by phone if we will not be open. If the weather is questionable, please call the office before leaving for your appointment to confirm that we are open.

Medication Refills:
When possible, we will try to have telephone refills ready by the end of business day, but in some instances they may not be ready until next business day. The nurse practitioners will review all request during lunch hours or at the end of day, and not during scheduled appointment times with patients. Please keep this in mind when you call for refills and do not wait until you are out of medication. Also be advised you can call your pharmacy and have them to fax over a refill request. Prescriptions for controlled substances are not called and patients must come in for appointment for any of those type prescriptions.

Self Pay Patients:
All new and established patients who do not have insurance coverage are required to pay on the day of services are rendered. When services are paid that day, patients will receive a 50% discount off their visit. All patients are also required to pay any outstanding balances before being seen in our office unless prior finical arrangements have been made.

Medicare Patients:

On January 1st of each calendar year Medicare requires that a $162 deductible be satisfied prior to benefits being paid at 80% of the reasonable and customary amount. If you have not met your deductable prior to your office visit you will be responsible for our charges until your deductible is met. Once the deductable is satisfied you will be responsible for 20% of your charges. The only exception to this is a secondary supplement pan that would cover the 20% of your charges. Please present all insurance cards to the front office upon your initial visit so this can be identified. If our office is aware that certain services are considered non-covered by Medicare, you will be asked to sign an Advanced Beneficiary Notice that we informed you of any non-covered services and your financial responsibility.

Medicaid Patients:

Your must have your Medicaid card available upon each visit to the office so that we can verify eligibility for that time period. If you do not have you Medicaid card available your appointment will have to be rescheduled for another date and time. If our office is aware that certain services are non-covered by Medicaid, you will be asked to sign an agreement with our office that you were made aware of this service not being covered and that you will be financially responsible for the service. Payments for non-covered service are expected the time of your visit.

Commercial Insurance Patients:

Upon your initial visit to our office please present your insurance card. You will be responsible for any applicable deductibles, co-pays and non –covered services that are required to be paid at the time of services rendered. Insurance claims are billed to your insurance company as a courtesy: however, it is your responsibility to understand your insurance benefits as well as how your insurance processed and pays your claims. When you receive a new insurance card it is imperative that you inform our office as soon as possible. Without the proper information we cannot correctly file your claims or schedule referral appointments, which could lead to substantial finical responsibility to you. Also at the time of your visit, if you have a co-pay with your insurance, it will be due time of services.

Referrals:

If our office feels that you need to be referred out to a specialist we will work on getting an appointment set up within 72 hours prior to your appointment. Most insurance companies require that you have a scheduled appointment with your PCP to be referred out to a specialist. . Please be advised on how you're insurance pays for specialty visit and procedures, so please check with your insurance company to make sure coverage is available for which you will be responsible for your own visit, any questions please contact your insurance company. Our office polices on referrals is that we work to get the patients into a specialist, so it is important that you must keep your appointments with the specialist. Once you have seen them and you are not satisfied with you referral or you get discharged from the specialist, you will be responsible for finding your next referral, which we only make one referral to each specialist. Please also be advised that specialty physicians are extremely busy and might take some time getting you into see them. If it is emergent situation you will most likely be worked in sooner. If any questions regarding referrals please contact our office.

This financial policy will be strictly adhered to with no exceptions unless prior arrangements have been made. Please direct any billing question to our office manage or you may call our billing office at 1-855-876-2412. Thank you for your cooperation.