FAMILY PRACTICE ASSOCIATES OF LEXINGTON, P.S.C.
1775 ALYSHEBA WAY; SUITE 201• LEXINGTON, KY 40509• (859) 278-5007• www.FPALEX.com

☐ New ☐ Updated Date: _____

PATIENT INFORMATION

Patient's Name: _____ Prefer to be called: _____

Date of Birth: _____ Social Security #: _____ Sex: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): (____)_____ (Work): (____)_____ (Cell): (____)_____

**The phone number listed as home will be used for appointment reminder calls.*

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's Employer *(if applicable)*: _____ Occupation: _____

Email Address: _____ Referred By: _____

EXTENDED INFORMATION

Spouse or Parent's Name: _____ Relationship: _____

Phone: (____)_____ Employer: _____

Emergency Contact: _____ Relationship: _____

Phone: (____)_____

INSURANCE INFORMATION

*(Patient **must** present card(s) at time of service)*

PRIMARY Insurance: _____ Effective Date: _____

Subscriber's Name *(if different than patient)*: _____

Subscriber's DOB *(REQUIRED)*: _____ Relationship: _____

**If your plan requires assignment of PCP, please contact your insurance to select one of our physicians.*

SECONDARY Insurance: _____ Effective Date: _____

Subscriber's Name *(if different than patient)*: _____

Subscriber's DOB *(REQUIRED)*: _____ Relationship: _____

MEDICARE PATIENTS ONLY

(REQUIRED)

1. Are you or your spouse covered by an Employer Group Health Benefit Plan? ☐ **Yes** ☐ **No**
2. Are you or your spouse working for an employer with more than 20 employees? ☐ **Yes** ☐ **No**
3. Do you receive Black Lung Benefits? ☐ **Yes** ☐ **No**
4. Do you receive workers comp benefits? ☐ **Yes** ☐ **No**
5. Are you being seen for an injury or illness for which another party could be held liable, or is covered under Automobile No-Fault Insurance? ☐ **Yes** ☐ **No**

CONTINUED ON REVERSE- SIGNATURE REQUIRED

Family Practice Associates of Lexington, PSC
(859) 278-6717
PATIENT FINANCIAL POLICY

Thank you for choosing Family Practice Associates of Lexington as your physician office. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients must complete this form prior to seeing the Provider.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and timely resolve any outstanding balances.

Insurance: Insurance coverage is a contract between you and your insurance company. Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by your insurance. If you are experiencing delays or difficulties with your insurer and payment of benefits, you should contact the Consumer Protection and Education Division of the Kentucky Department of Insurance at (800) 595-6053.

Demographic Information & Insurance Cards: It is extremely important that we have updated demographic data so that we will be able to contact you in the future. We also must have a current copy of your insurance card and a photo ID on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing by your insurance and those claims would become your financial responsibility.

Network Providers: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify and contact our Billing Office, if there is any question regarding network eligibility.

Co-pays, Co-Insurances & Deductibles: I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. I understand that I am responsible for any balance not covered by my insurance. We are required by all insurance carriers to collect all co-insurances, co-pays and deductibles.

Non-covered Services: It is possible that your insurance may not cover certain procedures or treatment for certain diagnoses. Please be aware that you will be responsible for any non-covered services.

Returned Checks: I understand that I will be charged an additional fee of $25 for any returned check.

Cancellation of Appointments: As a courtesy to other patients and the physicians, we require an advance notice prior to canceling appointments. Please call us if you are unable to keep your appointment. There may be a fee for failure to notify us in advance.

Payment: We accept Cash, Check, Money Orders, Mastercard, Visa, American Express, Discover and Debit Cards for payment. You may be contacted by our office at any of your contact numbers listed to attempt to resolve any outstanding balances. In the event that the account is not resolved, I understand that my account may be turned over to a collection agency and that I may be terminated as a patient of Family Practice Associates of Lexington PSC.

Outside Lab Services: For labs not performed by our staff, we may utilize an outside lab company. Charges for these services are not controlled by Family Practice Associates. Patients are responsible for knowing whether their insurance plan covers laboratory services and for making arrangements for payment with the servicing lab.

Medicare Assignment of Benefits/Authorization: I request that payment of authorized Medicare and/or any other government sponsored insurances of which I may be covered, be made on my behalf to Family Practice Associates of Lexington, P.S.C. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in the place of the original.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

Signature of Responsible Party	Relationship to Patient	Date

Patient Name(s): _____ DOB: _____

FAMILY PRACTICE ASSOCIATES OF LEXINGTON, P.S.C.

This is a 2-page form... please complete both sides!

Comprehensive Patient History

Patient Name _____ Date of Birth: _____ Soc. Sec.# _____

What is the reason for today's visit? _____ Today's Date _____

Describe the following (if applicable):

Location of pain: _____ How long have you had this problem? _____

How severe is this problem? ☐ mild ☐ moderate ☐ very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

List previous hospitalizations/Surgeries/Serious Injuries — When?

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies you have (food, drug, other: _____

_____

_____

_____

List all regular medications:

_____

_____

_____

_____

_____

Last Tetanus shot: _____

_____

Patient Social History

Occupation: _____

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

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily _____

Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day _____

Drug use: ☐ Never ☐ Type/Frequency _____

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Caffeine use: How many cups coffee/tea/soda/ per day? _____

Regular exercise: How often? _____

Is there a family history of the following?			Diabetes	yes	no	High blood pressure	yes	no
Cancer	yes	no	Stroke	yes	no	Heart trouble	yes	no
Arthritis/Gout	yes	no	Seizures	yes	no	Bleeding Tendency	yes	no
Acute Infections	yes	no	Venereal Disease	yes	no	Hereditary Defects	yes	no
Tuberculosis	yes	no	Asthma/emphysema	yes	no	HIV/AIDS	yes	no

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____

(Turn Over to other side)

FAMILY PRACTICE ASSOCIATES OF LEXINGTON, P.S.C.

This is a 2-page form... please complete both sides!

Patient Name _____

Have you recently experienced any of the following?

PLEASE ANSWER ALL QUESTIONS

GENERAL HEALTH & WELL-BEING			When?
Good general health lately	No	Yes	
Recent weight change	No	Yes	
Fever	No	Yes	
Fatigue	No	Yes	
Headaches	No	Yes	
EYES			
Eye disease or injury	No	Yes	
Wear glasses/contact lens	No	Yes	
Blurred or double vision	No	Yes	
Glaucoma	No	Yes	
EARS, NOSE, THROAT, SINUS			
Hearing loss	No	Yes	
Ringing in the ears	No	Yes	
Perforated (hole in) ear drums	No	Yes	
Earaches or drainage	No	Yes	
Sinus problems	No	Yes	
Seasonal nasal discharge (allergies)	No	Yes	
Loss of smell	No	Yes	
Nose bleeds	No	Yes	
Mouth sores	No	Yes	
Bleeding gums	No	Yes	
Bad breath or bad taste	No	Yes	
Sore throat or voice change	No	Yes	
Swollen glands in neck	No	Yes	
HEART AND CIRCULATORY SYSTEM			
Heart trouble	No	Yes	
Chest pains	No	Yes	
Palpitations or flutter of heart	No	Yes	
Swelling of feet, ankles or hands	No	Yes	
Shortness of breath that awakens you at night	No	Yes	
Cramping in legs	No	Yes	
High blood pressure	No	Yes	
LUNGS			
Frequent coughing	No	Yes	
Spitting up blood	No	Yes	
Shortness of breath	No	Yes	
Asthma or wheezing	No	Yes	
GENITOURINARY			
Frequent urination (voiding)	No	Yes	
Burning or painful urination	No	Yes	
Blood in urine or discoloration	No	Yes	
Change of force or strain when urinating	No	Yes	
Inability to control bladder or dribbling	No	Yes	
Getting up at night to pass urine	No	Yes	
Kidney stones	No	Yes	
Male - testicle pain	No	Yes	
Female - pain with periods	No	Yes	
Female - irregular periods	No	Yes	
Female - vaginal discharge	No	Yes	

Female - # pregnancies _____ # miscarriages _____

Female - date of last PAP smear _____

Female - findings of last pap smear ☐ Normal ☐ Abnormal

Female - date of last menstrual period _____

Last Mammogram? _____

Do you practice birth control?	No	Yes	

If so, what type: _____

GASTROINTESTINAL			When?
Loss of appetite	No	Yes	
Change in bowel movements	No	Yes	
Nausea or vomiting	No	Yes	
Heartburn or chronic indigestion	No	Yes	
Frequent diarrhea	No	Yes	
Painful bowel movements or constipation	No	Yes	
Red blood in stool or tarry, black stools	No	Yes	
Stomach pain	No	Yes	
Hemorrhoids or rectal itching	No	Yes	
BONES, JOINTS, MUSCLES			
Joint pain, stiffness, or swelling	No	Yes	
Weakness of muscles or joints	No	Yes	
Muscle pain or cramps	No	Yes	
Back pain	No	Yes	
Cold extremities (legs)	No	Yes	
Difficulty in walking	No	Yes	
SKIN			
Rash or itching	No	Yes	
Change in skin color	No	Yes	
Change in hair or nails	No	Yes	
Varicose veins	No	Yes	
Breast pain	No	Yes	
Breast lump	No	Yes	
Breast discharge	No	Yes	
BRAIN AND NERVOUS SYSTEM			
Frequent or recurring headaches	No	Yes	
Light headed or dizzy	No	Yes	
Convulsions or seizures	No	Yes	
Numbness or tingling sensations	No	Yes	
Tremors	No	Yes	
Paralysis	No	Yes	
Stroke	No	Yes	
Temporary blindness	No	Yes	
Loss of consciousness	No	Yes	
Weakness of any extremity (leg or arm)	No	Yes	
MENTAL HEALTH			
Memory loss or confusion	No	Yes	
Nervousness	No	Yes	
Depression	No	Yes	
Sleep problems	No	Yes	
ENDOCRINE			
Glandular or hormone problem	No	Yes	
Thyroid disease	No	Yes	
Excessive thirst or urination	No	Yes	
Heat or cold intolerance	No	Yes	
Dry skin	No	Yes	
Change in hat or glove size	No	Yes	
BLOOD AND LYMPH			
Slow to heal after cuts	No	Yes	
Easily bruise or bleed	No	Yes	
Anemia	No	Yes	
Phlebitis	No	Yes	
Past transfusion	No	Yes	
Enlarge glands	No	Yes	

Patient Signature _____

☐ *I have reviewed and confirmed this information with the patient.*

Today's Date _____

Provider Signature: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

My signature below indicates that I have been given an opportunity to read and obtain a printed copy of the Notice of Privacy Practices from Family Practice Associates of Lexington, P.S.C.'s web site.

_____ _____

Signature Date of Signature

_____ _____

Printed Name Date of birth

FAMILY PRACTICE ASSOCIATES OF LEXINGTON, P.S.C.
1775 ALYSHEBA WAY, SUITE 201
LEXINGTON, KY 40509
PHONE (859) 278-5007
FAX (859) 278-6867

AUTHORIZATION TO DISCUSS/DISCLOSE PROTECTED HEALTH INFORMATION

I give Family Practice Associates of Lexington, P.S.C. permission to discuss my **entire medical record and billing information** with the following specified persons or agencies.

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____

OR

Please discuss/disclose **only the following specified information** to the above named persons or agencies:

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such notification to FPA.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding privacy of my protected health information.

This authorization expires on _____

Patient's Printed Name _____ Date of birth _____

Signature of patient/representative _____ Date _____

Witness Signature _____ Date _____

FAMILY PRACTICE ASSOCIATES
OF LEXINGTON, PSC

PATIENT EXPECTATIONS	PATIENT RESPONSIBILITIES
1. Have the expectation to be treated in a manner reflecting respect for their privacy and dignity as a person.	1. Have the responsibility to be considerate and cooperative in dealing with office staff and providers.
2. Have the expectation to be informed regarding their diagnosis, course of treatment and prognosis in terms they can reasonably be expected to understand and to participate in decision making about their health.	2. Have the responsibility to follow instructions and guidelines given by those providing health care services and to weigh potential consequences of any refusal to comply with those instructions or recommendations.
3. Have the expectation to receive sufficient information to enable them to give informed consent prior to the initiation of any procedure and/or treatment.	3. Have the responsibility to obtain and carefully consider all information needed or desired in order to give informed consent for a procedure or treatment.
4. Have the expectation to discuss their medical record with the physician and to receive, upon written request, a copy of that record.	4. Have the responsibility to assist in compiling a complete medical record by providing or authorizing release of medical information from other providers.
5. Have the right to expect information pertaining to their health care will be treated as confidential and will not be released without their, or their authorized representative's written permission, except as required by law.	5. Have the responsibility to notify their primary care physician (PCP) prior to seeking consultation or emergency services, except in potentially life threatening situations.
6. Have the expectation to be informed of unforeseen delays in the provider's schedule.	6. Have the responsibility to schedule appointments and to arrive on time for scheduled visits or to notify their physicians' offices if they must cancel or be late for a scheduled appointment.
7. Have the expectation to be able to make a complaint and to receive response to that complaint within a reasonable period of time.	7. Have the responsibility to express opinions, concerns or complaints in a constructive manner.

Family Practice Associates
of Lexington, P.S.C.

Self-Pay Accounts

For our uninsured accounts, Family Practice Associates of Lexington requires a minimum deposit of:

- $50.00 for established patients and
- $100.00 for new patients to be paid upon check in.

The remainder of the balance will be collected at check-out. The actual charge is not determined until the office visit is completed. Prices on office visits can vary depending on the extent of the visit. A 30% discount will be applied if payment is made in full on the date of service.

We do not accept long-term payment arrangements on our accounts. Accounts not paid in full on the date of service will be processed thru the normal collection procedures. If monthly payments are not made on the account, the account will be referred to a collection agency.

Hopefully, this has explained how your account will be handled. If you have any questions regarding your account, please do not hesitate to call our business office at (859) 278-6717.

Family Practice Associates of Lexington