LAKE CUMBERLAND PHYSICIAN PRACTICES, LLC

PATIENT REGISTRATION FORM

Today's Date ____/____/_____

PATIENT INFORMATION

Patient Name Last	First	Middle	▫ Mr ▫ Mrs ▫ Miss ▫ Ms	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 ▫ T
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	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: **City:** 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

Primary Care Physician Phone #

RESPONSIBLE PARTY INFORMATION

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 at check-in)

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**		
Name of Insured	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	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ▫ Self ▫ Spouse ▫ Child ▫ Other _____					

EMERGENCY CONTACT

Name (Last, First)	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.

_____ _____

Patient/ Guardian Signature Date

Lake Cumberland Cardiology Associates

Dr. Michael E. McKinney, M.D., F.A.C.C

Patient's Name:_____ DOB:_____ Date:_____

Reason for being seen today:_____

Medications you currently are taking, please list the strength and dosing on each medication.

_____

_____

_____

_____

_____

_____

_____

_____

Medication History:

Diabetes: Y N High Blood Pressure: Y N Cancer: Y N

Stroke: Y N Heart Trouble: Y N Arthritis: Y N

Free Bleeder: Y N Passing Out: Y N Stomach bleeding or Ulcer: Y N

Alleriges:_____
Surgeries:_____
Hospitalizations:_____

_____

Family History: Answer all that applies

Relation	Alive/Dead	Diabetes	Hypertension High Blood Pressure	Coronary Artery Disease	Cancer Type	Psychiatric
Mother						
Father						
Brother # 1						
Brother #2						
Sister #1						
Sister #2						

Social History:

Tobacco Use: Y N Daily: Y N How many daily:_____ Are you ready to quit: Y N

Alcohol Use: Y N Street Drugs: Y N Are you married: Y N

Review of Systems:

General:

Fever: Y N

Significant Weight Changes: Y N Gain/Loss (if yes circle one)

Ear/Nose/Mouth/Throat:

Ear Ringing: Y N

Difficulty Swallowing Y N

Pulmonary:

Cough: Y N

Wheeze: Y N

Sleep Apnea: Y N

Cardiovascular:

Passing Out: Y N

Non Healing Leg Wound: Y N

Leg Pain: Y N

Gastrointestinal:

Nausea/Vomiting: Y N

Jaundice: Y N

Urinary:

Blood In Urine: Y N

Pain With Urination: Y N

Musculoskeletal:

Muscle Cramps: Y N

Joint Swelling: Y N

Skin:

Rash: Y N

Sores: Y N

Neurological:

Tremors: Y N

Numbness: Y N

Psychiatric:

Hallucinations: Y N

Suicidal Thoughts: Y N

Endocrine:

Heat/Cold Intolerance: Y N

Thyroid Disorder: Y N

Michael E. McKinney, M.D., F. A. C. C.

Lake Cumberland Cardiology Associates

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) 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 Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S): Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes

discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates

FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

_____

Date

Lake Cumberland Cardiology Associates

Dr. Michael E. McKinney, M.D., F.A.C.C

Interventional Cardiologist

120 Trade Park Drive, Suite B.

Office: (606) 678-0599 Fax: (606) 678-0608

Authorization to Release Medical Information

Full Legal Name: _____ DOB: _____

To release information to: _____

I herby authorize: _____

To release information to:

The following medical records information:

____ Laboratory Reports ____ Procedure Reports

____ Consultation Reports ____ Diagnostic Testing

____ Physician Progress Notes

____ Other _____

From the dates of _____ to _____

This information is strictly confidential and the consent is only for the person to whom it is addressed. This information has been disclosed for records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of the information unless further disclosure is specifically permitted in the patient's written consent or as permitted by law. The federal rules restrict any use of this information to criminally investigate or prosecute.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____