Consent for Purpose of Treatment and Health Care Operations

I consent to the use or disclosure of my protected health information for Bluegrass Orthopaedics (BGO) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to contact health care operations of BGO.

I understand that diagnosis or treatment of me by BGO may be conditioned upon my consent as evidence by signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. BGO is not required to agree to the restrictions that I request, however, if BGO agrees to a restriction that I request, the restriction is binding on BGO and any health care provider of BGO.

I have the right to revoke this consent in writing at any time except to the extent that BGO or any health care provider of BGO has taken action in reliance on the consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to revoke BGO Notice of Privacy prior to signing this document. BGO Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected information that will occur in my treatment, payment of my bills, or in the performance of health care operations of BGO. The Notice of Privacy Practices is also posted in the office and on the website bluegrassortho.com.

The Notice of Privacy Practices also describes my rights and the duties of BGO with respect to my protected health information.

I understand BGO and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number or electronic mail address I have provided, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers or electronic mail addresses, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify BGO if I have given up ownership or control of any such telephone number or electronic mail address.

BGO reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the BGO website, or calling the office and requesting a revised copay be sent in the mail or asking for one at the time of my next appointment.

Account #: _______________

PRINT PATIENT NAME: ____ DOB: ______/______/______

SIGNATURE OF PATIENT: ____ Date: ______/______/______

Signature of Personal Representative if patient is unable to sign: ____

Personal Representative's Relationship: ______________________ Witness (on behalf of BGO): _____________________

IF YOU ARE NOT AVAILABLE WHEN WE CALL, MAY WE HAVE PERMISSION TO LEAVE A MESSAGE EITHER ON YOUR VOICEMAIL OR WITH ANOTHER PERSON? YES _______ NO _______

PLEASE LIST THE NAMES OF FAMILY MEMBERS OR FRIENDS THAT WE MAY DISCUSS YOUR CARE WITH AND IDENTIFY THEIR RELATIONSHIP TO YOU.

NAME:	RELATIONSHIP:	PHONE:
________________________________	____	
________________________________	____	
________________________________	____	

Bluegrass Orthopaedics Authorization Form

3480 Yorkshire Medical Park ◆ Lexington, KY 40509 (859)263-5140 FAX (859) 263-5141

I, ___________________________________, hereby authorize Bluegrass Orthopaedics to use and/or disclose my protected health information described below to____

____.

My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):____.

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

- □ Any and all records in the possession of Bluegrass Orthopaedics including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)
- □ Itemized billing statement
- □ Records coving the period of time ______/______/______ to ______/______/______.
- □ Records regarding treatment for the following condition or injury ________________ ____ on or about ____.
- □ X-Rays
- □ MRI
- □ CD
- □ Other (please specify – include dates): _____________________________________.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Manager – Health Information. 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 Bluegrass Orthopaedics may not condition 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 year from the date signed **OR** in the event of ___________________________________.

____   ____/____/____
Signature of Patient or Personal Representative   Date

____   ____
Printed Name of Patient or Personal Representative   Description of Personal Representative's Authority

________________________   ____/____/____   ________________________
Acct #   DOB   Social Security #

Patient History

Date: _____/_____/_____

Account #: _________________

Patient #: _________________

Patient Name: ________________________________ Height: _____ Weight: _____ DOB: _____/_____/_____

Employer: _________________Referring Doctor: _________________Primary Care Provider: ________________

MEDICATIONS (Please list all medications you are currently taking, including prescriptions and over the counter):

ALLERGIES: LATEX: ☐ YES ☐ NO **METAL:** ☐ YES ☐ NO **NICKEL:** ☐ YES ☐ NO **DRUG ALLERGY:** ☐ YES ☐ NO **SUTURES:** ☐ YES ☐ NO **TAPE:** ☐ YES ☐ NO

Please list all medications you are allergic to: ____

____

HISTORY OF INJURY:

Did the problem result from a specific injury? ☐ YES ☐ NO DATE OF INJURY: __________________

Was your injury a result of a fall? ☐ YES ☐ NO Age: _______

☐ Work Injury ☐ Auto Accident OTHER: ____

History of Pain: ☐ Gradual ☐ Sudden ☐ Chronic Pain Scale 1-10:__________________________

Is the pain: ☐ Sharp ☐ Dull/Aching ☐ Throbbing ☐ Stabbing ☐ Occasional ☐ Constant Symptoms:

____

Previous Treatment: ☐ YES ☐ NO Doctor: ____

What treatments have you tried? ☐ Nothing ☐ Physical Therapy ☐ Injections ☐ Bracing

☐ Medications: ________________________________ ☐ OTHER: ______________________________

Please check the following tests that are related to this injury/problem. List date and facility.

TEST	**DATE** (month/year)	**FACILITY**
☐ X RAY	____________________________	_________________________________
☐ CT SCAN	____________________________	_________________________________
☐ MRI	____________________________	_________________________________
☐ EMG/NCV	____________________________	_________________________________
☐ LABS	____________________________	_________________________________
☐ OTHER	____________________________	_________________________________

PATIENT NAME: ____ DOCTORS INITIALS: _________

PAST SURGICAL HISTORY

Please check all that apply

- ☐ APPENDECTOMY
- ☐ HEART SURGERY
- ☐ GALLBLADDER SURGERY
- ☐ BACK/SPINE SURGERY
- ☐ HERNIA REPAIR
- ☐ TOTAL HIP
- ☐ TOTAL KNEE
- ☐ TOTAL SHOULDER
- ☐ HYSTERECTOMY
- ☐ C SECTION
- ☐ PREVIOUS FRACTURE ☐ ADDITIONAL SURGERIES:

____

____

____

MEDICAL HISTORY

Please check all that apply

☐ Anemia	☐ Rheumatoid
☐ Arthritis	☐ Heart attack/stroke
☐ Blood Clots	☐ Thyroid
☐ Cancer	☐ Diverticulitis
☐ Depression	☐ Gastric Ulcer
☐ Diabetes	☐ Kidney Disease
☐ Emphysema	☐ Polio
☐ Heart Disease	☐ High Cholesterol
☐ Liver Disease	☐ Heartburn
☐ Hepatitis A or B	☐ Acid Reflux
☐ Hypertension	☐ Irregular Heartbeat
☐ HIV	☐ Blood Transfusion
☐ Osteoporosis	☐ History of Multiple Fractures

☐ Pneumonia Vaccination-Date of Vaccination: ____/____/____

Other: ____

____

SOCIAL HISTORY

Special Diet:	☐ YES	☐ NO	______________________
Smoker:	☐ YES	☐ NO	______________________
Smokeless Tobacco:	☐ YES	☐ NO	______________________
Alcohol:	☐ YES	☐ NO	______________________
Drug Use:	☐ YES	☐ NO	______________________
Caffeine:	☐ YES	☐ NO	______________________
Exercise:	☐ YES	☐ NO	______________________

FAMILY HISTORY

Please check all that apply & circle the applicable family member

☐ Blood Clots	MOTHER/ FATHER/ SISTER /BROTHER
☐ Heart Disease	MOTHER/ FATHER/ SISTER/ BROTHER
☐ Diabetes	MOTHER/ FATHER/ SISTER /BROTHER
☐ Hypertension	MOTHER/ FATHER/ SISTER/ BROTHER
☐ Osteoporosis	MOTHER/ FATHER/ SISTER/ BROTHER
☐ Rheumatoid	MOTHER/ FATHER/ SISTER/ BROTHER
☐ Cancer	MOTHER/ FATHER/ SISTER/ BROTHER
☐ Stroke/Seizures	MOTHER/ FATHER/ SISTER/ BROTHER

OTHER SIGNIFICANT FAMILY HISTORY:______________

____

____

PATIENT NAME: ____ DOCTORS INITIALS: __________

1) CONSTITUTIONAL GENERAL	☐ NONE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ INSOMNIA ☐ FATIGUE ☐ OTHER:
2) EYES	☐ NONE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ CATARACTS ☐ OTHER:
3) EARS, NOSE, THROAT	☐ NONE ☐ HEARING LOSS ☐ SEASONAL ALLERGIES ☐ SINUS ☐ OTHER:
4) CARDIOVASCULAR	☐ NONE ☐ CHEST PAIN ☐ EDEMA ☐ PALPITATIONS ☐ OTHER:
5) RESPIRATORY	☐ NONE ☐ WHEEZING ☐ FREQUENT COUGH ☐ OTHER:
6) GASTROINTESTINAL	☐ NONE ☐ ULCER PROBLEMS ☐ ABDOMINAL PAINS ☐ OTHER:
7) MUSCULOSKELETAL	☐ NONE ☐ MUSCLE WEAKNESS ☐ JOINT PAIN ☐ BACK PAIN ☐ OTHER:
8) SKIN	☐ NONE ☐ RASH ☐ SCARS ☐ DRY SKIN ☐ OTHER:
9) NEUROLOGICAL	☐ NONE ☐ HEADACHES ☐ SEIZURES ☐ NUMBNESS ☐ DIZZINESS ☐ OTHER:
10) PSYCHIATRIC	☐ NONE ☐ DEPRESSION ☐ CRYING ☐ ANXIETY ☐ MOOD SWING ☐ OTHER:
11) ENDOCRINE	☐ NONE ☐ HOT FLASHES ☐ EXCESSIVE SWEATING ☐ OTHER:
12) HEMATOLOGY	☐ NONE ☐ EASY BRUISING ☐ BLEEDING ☐ CLOTTING DISORDER ☐ OTHER:

____ ________/_______/_______

PATIENT SIGNATURE, Guardian if patient is a minor DATE

Controlled Substance Agreement

Patient Name: ____ Pharmacy: _____________________________________

Pharmacy Location: ____ Pharmacy Phone: _______________________________

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids", to treat pain related to my injury. I will be provided with prescriptions only if I understand and agree to the following:

1. Have you ever been diagnosed with or treated for substance abuse? □ Yes □ No

If yes, please explain:____

2. Have you ever been arrested for illegal possession of a controlled substances? □ Yes □ No

3. If yes, please explain:____

By signing this agreement:

- I agree that the medication will be stopped should my functional ability not improve, should it lose its effectiveness, or should I be found to be misusing the medications in any way.
- I understand that this medication is potentially addictive and the chances of addiction are greatly decreased if these medications are prescribed to me in a strict and controlled environment under the guidance of my physician. I understand this includes regular office visits to assess my progress.
- I agree to take the medication only as prescribed and will not change the dose without getting approval from my physician. I understand that my physician may not approve the changes in dosage.
- I will obtain pain medication prescriptions only from the doctor named above. Violation of this requirement will result in tapering and discontinuing of the drug. In the event that this doctor is not available to write the prescription when due, I understand that only a partial prescription will be given until my physician returns.
- No prescription that is "lost, misplaced or stolen" will be replaced. Using too much of these medications will not be tolerated and the prescription will not be filled early for any reason. I understand the Drug Enforcement Agency has strict guidelines forbidding these actions and my physician must abide by these rules.
- If I am unable to tolerate my medication, I will return the unused portion of the medication to my physician, before I am given a prescription for another similar medication.
- I understand that, at some point in my treatment, my physician will discuss with me a scheduled taper and or discontinuation of the medication and I agree to follow this schedule.
- I understand that controlled substances can cause sedation, confusion or other changes in mental state and thinking abilities. I understand that the decision to drive while I'm taking controlled substances is my own decision and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for him/herself if I am in any way sedated, feel drowsy or not thinking clearly.

Medical release of information – I hereby authorize Bluegrass Orthopaedics to obtain and release medical information from/to physicians, clinics, hospitals, or other health care providers including pharmacies:

____________________________	____/____/____	________________________________	____/____/____
Witness by BGO Staff Member	Date	Patient Signature, Guardian if patient is a minor	Date

Medication Refills

Please read the following information on how prescription refill requests are handled through our office.

For your convenience, you may submit all prescription requests online at our patient portal, **bgo.portalforpatients.com**. (For information on registering for the patient portal, please ask an associate.)

If you do not have internet access, the prescription line can be directly dialed at 859-422-4549 for all prescription requests including new ones. Prescription requests should be called into the office between 8:30am and 4:00pm, Monday through Friday.

To handle your request as promptly as possible, our interactive voicemail will ask the following questions:

1. Your name (spell the last name), press # key
2. Date of birth, press # key
3. Social security number, press # key
4. Daytime phone number to be reached (with area code), press # key
5. Name of medication, press # key
6. Pharmacy name, press # key
7. Pharmacy phone number (with area code), press # key
8. Allergies to medications, press # key
9. The doctor's name at Bluegrass Orthopaedics that is treating you, press # key
10. Reason for requesting the medication, press # key

NOTE: If information is missing or not clear, it may slow our ability to fill your request.

Please call the office and request your medication refill before the last day of medication. Once you leave a message on the prescription line, you do not have to call us back to see if your doctor has approved your refill. If it is denied, we will contact you. Please do not leave medication refill requests on the Clinical Assistant's voicemail, as this will only slow your request down. The Physician Assistants (PA's) do not call in prescriptions after hours or on weekends.

Thank you,

The Staff of Bluegrass Orthopaedics