KENTUCKY ORTHOPAEDICS & SPINE

Gregory Grau, M.D. James Rice, M.D. David Waespe, M.D. Amy Barko, DPM Shawn L. Price, M.D. Jorge D. Benito, DO
Jason Delong, PA-C *Brandon Embry, PA-C* *Kurt Schlenther, PA-C* *Kendall McCarty, PA-C*
Sarah Ervin, PA-C *Michael Bradley, PA-C* *Nicholas Music, PA-C*

Patient Information

Patients Last Name First MI	Sex	Birth Date	Social Security #	Home Phone #
				( )
Preferred Language	Race		Ethnicity	_____Hispanic _____Non-Hispanic
Mailing Address	City, State, Zip		Cell Phone #	
			( )	
Patients Employer or School (If applicable)	Spouse/Parent(s) Name		Spouse's Birth Date	Spouse's SS#
Marital Status	Number of Children		Do you have a living will?	
Employer Address	City, State, Zip		Work Phone #	
			( )	
In Case of Emergency Contact:	Relationship		Phone #	
			( )	
Email Address				

Who may we discuss your health information with?

- o No one other than self
- o Spouse
- o Parent
- o Other _____

May we leave messages regarding your health information on your voicemail/answering machine?

Referring Physician:	Primary Care Physician:

WE MUST HAVE A COPY OF YOUR INSURANCE CARDS IN OUR FILES. PLEASE PRESENT CARD TO RECEPTIONIST.

CONSENT

- I hereby consent Kentucky Orthopaedics & Spine to use or disclose my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me (including any health, auto, or workers compensation carrier) or to carry out the Practice's health care operations. I also consent Kentucky Orthopaedics & Spine to use or disclose my protected health information to other treating physicians if an outside referral is necessary or to any facility at which I may be treated or evaluated.
- I hereby give my permission to Kentucky Orthopaedics & Spine for the evaluation and treatment of the presented condition.
- I hereby authorize payment of insurance benefits, including Medicare, to Kentucky Orthopaedics & Spine and its providers. I understand that I am financially responsible for any charges not covered under this assignment. I certify that all my information is true and correct.

_____ _____/_____/_____
Patient or Responsible Party Signature Date

PLEASE COMPLETE ENTIRE FORM/ CONTINUED ON BACK PAGE....

REQUESTING TO SEE A PHYSICIAN
PLEASE READ CAREFULLY

Due to our Physician's surgical demands and the volume of patients seen in our office, we utilize Board Certified Physicians Assistants (PAs).

Kentucky Orthopaedics & Spine prides itself on the high caliber of its PAs. They complete routine continuing education and are highly educated in their field. Our surgeons have nothing but the utmost confidence in the PAs employed at Kentucky Orthopaedics & Spine and their skill level.

Our physicians and their PAs work from a combined daily schedule.
At any time, you may be seen by a PA, even if otherwise requested.

Requesting to see a physician may cause longer wait times, delayed scheduling and cannot be guaranteed.

Please note: Our surgeons are required to address emergency surgeries off-site when necessary. This can result in last minute changes to clinic schedules for both patients and the providers.

By signing below, I acknowledge I have read and understand the above notice. Any questions or concerns I may have were addressed by the practice staff or providers.

_____ _____

Signature of patient or representative Date

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History & Physical Form

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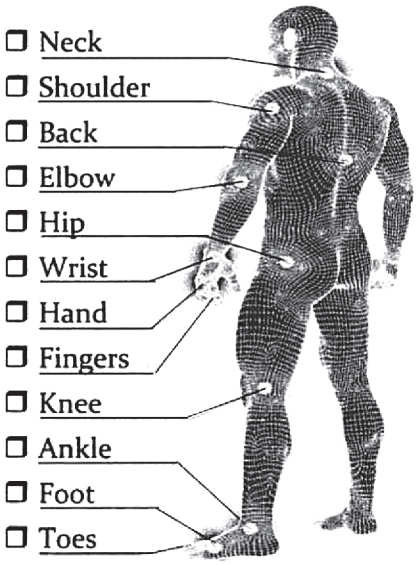
Name: _____ DOB: ____/____/____ Age:_____ Date: ____/____/____

Side: ❑ Left ❑ Right



- ❑ Neck
- ❑ Shoulder
- ❑ Back
- ❑ Elbow
- ❑ Hip
- ❑ Wrist
- ❑ Hand
- ❑ Fingers
- ❑ Knee
- ❑ Ankle
- ❑ Foot
- ❑ Toes

Pain Frequency	Pain Level
❑ 0	❑ 0
❑ 1	❑ 1
❑ 2	❑ 2
❑ 3	❑ 3
❑ 4	❑ 4
❑ 5	❑ 5
❑ 6	❑ 6
❑ 7	❑ 7
❑ 8	❑ 8
❑ 9	❑ 9
❑ 10	❑ 10

Which provider are you seeing today?

- ☐ Gregory Grau, M.D.
- ☐ James Rice, M.D.
- ☐ David Waespe, M.D.
- ☐ Amy Barko, DPM
- ☐ Shawn L. Price, M.D.
- ☐ Jorge D. Benito, DO
- ☐ Jason Delong, PA-C
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- ☐ Sarah Ervin. PA-C
- ☐ Michael Bradley, PA-C
- ☐ Nicholas Music, PA-C
- ☐ Kendall McCarty, PA-C

Height: _____ Weight: _____ Who referred you to us? _____

How long have you had the pain?_____ Is the pain resulting from an injury? ❑ Yes ❑ No

If an injury, please provide **date of injury** and describe how you were injured or what type of problems you are having now.

____/____/____ _____

_____

_____

Have you been treated previously by another orthopaedic doctor for this body part? ❑ Yes ❑ No

***If yes, please bring any X-Rays, MRI Films, or any other Medical Records that may be pertinent to this visit**

Any previous problems or injuries? ❑ Yes ❑ No If yes, please describe: _____

_____

Physician: _____ Hospital: _____ City: _____ State: _____

Is this a **Work** injury? ❑ Yes ❑ No If so, is Worker's Comp involved? ❑ Yes ❑ No

Is this a **Sports** injury? ❑ Yes ❑ No If so, what level do you play? ❑ Recreational ❑ Junior/High School ❑College ❑ Professional

Check ANY previous treatments and/or testing for this injury?

❑ X-rays ❑ CT Scans ❑ MRI ❑ Physical Therapy ❑ Injections ❑ Surgery
❑ Medications ❑ Chiropractor ❑ Acupuncture

Have you consulted or retained an attorney regarding this injury? ❑ Yes ❑ No

Office use only: Physician/Nurse signature required (initial & date): _____ ____/____/____

Current Medical History

Past Medical History	
❒	Anemia
❒	Asthma
❒	Bleeding/Hematology DZ
❒	Blood Clots
❒	Cancer
❒	Cardiac History
❒	Diabetes
❒	Gout
❒	High Cholosterol
❒	HIV / AIDS
❒	Hypertension
❒	Kidney Disorders
❒	Liver, Stomach, Bowel Disease
❒	Osteoarthritis
❒	Osteoporosis
❒	Rheumatoid Arthritis
❒	Thyroid Disorders
❒	Other:

Past Medical History Continued:

Have you ever had a reaction to anesthesia? ❒ Yes ❒ No

Do you have a pacemaker? ❒ Yes ❒ No

Past hospitalizations (NOT for surgery) ❒ None _____

_____

_____

_____

_____

What past operations have you had? When? ❒ None _____

_____

_____

_____

_____

REVIEW OF SYSTEMS -- Please check all that apply

CONSTITUTIONAL	
❒	Fever
❒	Decrease in Appetite

EYE	
❒	Blurry Vision
❒	Vision Problem

CARDIOVASCULAR	
❒	Chest Pain
❒	Heart Disease
❒	Hypertension

RESPIRATORY	
❒	Chronic Cough
❒	Shortness of Breath
❒	Wheezing

GASTROINTESTINAL	
❒	Heartburn
❒	Nausea
❒	Vomiting
❒	Hepatitis

GENITOURINARY	
❒	Dysuria
❒	Renal Disorders

HEME / LYMPH	
❒	Easy Bruising
❒	Anemia
❒	HIV Infection

ENDOCRINE	
❒	Thyroid Disorders
❒	Diabetes Mellitus

SKIN	
❒	Skin Rash
❒	Skin Lesions

NEURO	
❒	Headache
❒	Dizziness
❒	Seizures

MUSCULOSKELETAL	
❒	Joint Stiffness
❒	Diabetes Mellitus
❒	Osteoporosis
❒	Joint Swelling
❒	Upper Back Pain
❒	Lower Back Pain
❒	Gout
❒	Rheumatoid Arthritis
❒	Ankle Joint Swelling

❒ Depression
❒ Alcohol Use
❒ Drug Use

Are you currently being treated for any of the conditions you have checked above: ❒Yes ❒No **If no, please follow up with your primary care physician.**

SOCIAL HISTORY -- Please check all that apply

Work	
❒	Working Full Time
❒	Working Part Time
❒	Currently on disability
❒	Not working

LIVING SITUATION	
❒	Live with spouse
❒	Independently alone
❒	Living in a nursing home

Alcohol History	
❒	Never Drank Alcohol
❒	Being a Social Drinker
❒	Heavy Alcohol Consumption

TOBACCO	
❒	Previous Smoker
❒	Chew Tobacco
❒	Smoking Cigarettes
❒	Do not Smoke

DRUG USE - PRIVATE INFORMATION	
❒	Marijuana
❒	Cocaine
❒	Intravenous Drugs

MARITAL STATUS	
❒	Currently Married
❒	Divorced
❒	Never Married
❒	Single
❒	Separated
❒	Widowed

HABITS	
❒	Exercise

Current Medical History

Family Medical History - Please check all that apply								
❒	Alcoholism	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Anemia	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Cancer	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Chronic Disabling Disease	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Diabetes Mellitus	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Gout	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Heart Disease	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	High Cholesterol	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	HIV / AIDS	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Hypertension	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Kidney Disease	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Liver Disease	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Osteoarthritis	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Osteoporosis	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Rheumatoid Arthritis	❒	Father	❒	Mother	❒	Brother	❒ Sister
❒	Other:	❒	Father	❒	Mother	❒	Brother	❒ Sister

Medications:

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list: _____

_____

Are you taking, or have you taken any blood thinners? ❑ Yes ❑ No If yes, please list: _____

Medication / Vitamins	Dosage	Frequency

PLEASE SIGN: The information on these forms are accurate to the best of my knowledge.

Signature _____ Date _____

FOR OFFICE USE ONLY

Reviewed by _____ MD / Nurse Date: _____ Reviewed by _____ MD / Nurse Date: _____

Policies Regarding Medication, Consents & Privacy
PLEASE READ CAREFULLY AND INITIAL EACH LINE!

Please note: In our specialty, medications are not an emergent situation. Nor are they something that we are required to supply to any patient. We will do our best to keep you comfortable while you heal from the orthopedic issue for which we are treating.

_____CONSENT TO BE TREATED WITH CONTROLLED SUBSTANCES: I consent to be treated with a controlled substance(s) if my providers deem it necessary. I understand that I am not required to take these medications and will discuss any concerns with my provider at the time of the exam.

_____CONSENT TO NOTIFY PRIMARY & REFERRING PROVIDERS: I consent to my treatment and care plans, as well as any other correspondence, being sent to my primary care physician or referring physician in order to keep them up to date on any care Kentucky Orthopaedics & Spine may be providing.

_____REFILLS: Any medication refills requested by phone may take up to 7-10 days to be addressed, and either approved or declined by prescribing provider. If requesting refills by phone, please provide the spelling of your name, phone number, spelling of the requested medication, pharmacy name and phone number. Other physicians in the office will NOT refill medication if they were not the original prescribing provider.

_____PAIN MEDICATIONS & KASPER REPORTING: Medications prescribed by our providers in this office are for limited medical conditions and injuries, including acute fractures and post-operative pain. Pain medications ARE NOT given for chronic conditions. I understand that my provider will request a KASPER (KY All Scheduled Prescription Electronic Report) and may base the decision to provide controlled substances based on that report.

_____Any medication being requested while you are in the office must be done with the provider while you are in the exam room with them. We will not interrupt clinic to address medication requests or questions once you have left the exam room. THIS INCLUDES THE CHECK-OUT WINDOW. At that time, your request will be entered into our medication log and addressed by your provider when they are in the office.

_____Patients are responsible for their own medication. We WILL NOT replace lost or stolen medications. No exceptions.

_____DRUG SCREENS: By law, periodically, you will be required to perform a urine and/or swab drug screen or can be subject to a random pill count. You will be asked to disclose any/all medications you are taking. If you fail this screen for medications which you did not disclose, you may be temporarily or permanently suspended from the practice, at the doctor's discretion. If you fail this screen for illegal narcotics or recreational drugs, you will be permanently discharged from our practice. If you are asked to produce a urine sample during an office visit, you have 30 minutes to do so. If you cannot comply, this is an automatic failed screen. You will not be supplied with narcotic medications. If you leave the building while waiting to supply a urine sample, this is an automatic failed screen. You will not be supplied with medication and may be discharged from the practice. If you are signed up for surgery and fail a drug screen, you are required to pass two additional screens which will be done at random. We will not let you know when these will be requested. You will receive a phone call from our office the day you need to complete the screen w/ a required time in which you must arrive by. If you're not on time, this is an automatic failure. No exceptions.

_____ELECTRONIC PRESCRIBING: As of January 1, 2021, medical providers are required to prescribe all medications electronically. Please be sure that you have provided the office with the pharmacy in which you would prefer your medications be sent. Prescriptions will only be sent your pharmacy during normal business hours. By initialing this line, you acknowledge that you have been made aware of this regulation and will provide appropriate prescribing information about your pharmacy preferences below.

_____CONSENT TO OBTAIN MEDICATION HISTORY: The purpose of this consent is for permission to obtain your medication history from your pharmacy or other providers. The collected information is stored in the practice electronic medical record system and becomes part of your medical record. By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

Pharmacy Name:_____ **City:**_____ **Phone #:**_____

Additional Pharmacies Used:_____

_____

_____HIPAA PRIVACY POLICY: I have been offered and/or read and/or received a copy of the office polices, medication, financial and HIPAA privacy policy statements for Kentucky Orthopaedics & Spine and agree to the terms within. I also understand that such terms may be amended when needed by the practice and I will be notified of any changes.

*Note: a copy of our HIPAA Privacy Policy is posted in our office for your reference. We can supply you with a copy at your request. *

By signing below, you acknowledge that you have read the above statements and understand them. *No exceptions will be made to the above polices.*

_____ _____ _____

Patient Signature | Print Name and DOB | Date

ATTENTION PATIENTS AND VISITORS

At Kentucky Orthopaedics, we pride ourselves on being a healing environment.

Aggressive behavior toward our staff or providers will not be tolerated.

We do our best to accommodate our patients and their requests while following laws & processes set forth by our doctors & administrative staff, as well as abiding by government regulations, and contractual agreements we hold with your insurance carriers.

EXAMPLES OF AGGRESSIVE BEHAVIOR ARE: physical assault, verbal harassment, abusive or offensive language or tone of voice, threats, and name calling.

Kentucky Orthopaedics & Spine has a ZERO TOLERANCE policy for any form of aggression toward staff or providers. Failure to follow this policy will result in police being requested on-site, and immediate/permanent dismissal from our practice.

Thank you for your courtesy and respect.

_____ _____

Patient Signature Date

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Miscellaneous Consents and Authorizations

1. **Telehealth Visits:** I understand that techniques of telemedicine may be employed to facilitate my care. Those techniques may include electronic transmission of radiological images, remote access to lab results, or electronic correspondence regarding my care or documentation within my chart. Telehealth technology may also be used for diagnosing, education or follow-up visits.
2. **Pre-admission certification & release of information:** I authorize payment of my insurance benefits to the practice. I further authorize release of information required by any insurer or third-party payer regarding claims relating to my care. I understand that I am financially responsible for monies not paid by my insurance policy and/or third-party payer if required under the terms of the contract I hold with those carriers. I will personally be responsible for all or part of the cost of professional services if payment of those services are denied due to my failure to provide correct coverage information or my failure to obtain appropriate certifications or referrals, based on my policy's requirements.
3. **Certification/Authorization for Medicare or Medicaid Benefits:** I certify that the information given by me in applying for payment under Title XVII (Medicare) or Title XIX (Medicaid) of the Social Security Act or under any other governmental health care program or third-party is correct. Furthermore, I authorize anyone having medical or other information about me pertinent to my qualification for Medicare or Medicaid programs or benefits to release to and to secure from the Social Security Administration, the State Medical Assistance Program or to other agencies or entities administering the Medicare and Medicaid programs, request that payment of authorized benefits be made on my behalf directly to the practice qualifying for reimbursement for such medical care and treatment, including consultations, provided to me.
4. **Worker's Compensation Authorization:** If my visit to the practice is a result a work-related injury, I hereby waive any privilege I may have with the provider, and I hereby authorize these providers to provide the worker's compensations administrator any information, including but not limited to, the right to inspect and copy all of my medical records, regardless of relation to my injury. In the event there is a dispute about the compensability of my claim or worker's compensation benefits, and if my employer is not specifically determined by a Court of the Department of Labor to be responsible for worker's compensation medical expenses for the condition or injury that is the basis for my visit, I agree to be personally responsible for all such expenses. I further agree if my worker's compensation injury claim is settled with my employer on a disputed basis without a specific finding that is compensable as a worker's compensation injury, I (or my attorney I am represented by one) will withhold sufficient funds from any settlement to pay all amounts owed to the practice for treatment of the condition which is the basis for this visit or course of treatment. I hereby grant an assignment to the practice or it's providers for payment of all such expenses under such circumstances.

_____ _____

Patient's Signature Date

_____ _____

Printed Name Date of Birth