THE CECIL SPECIALTY CLINIC

1009A Dupont Sq N
Louisville, KY 40207
PH: (502) 894-9950 | FAX: (502) 894-9991

(Referring practice demographic sheet and insurance card can be used if it contains the following information)

Patient Name (Last) _____(First)_____(M)_____ Age _____

Street Address _____ City _____

State _____ Zip _____ SS# _____ DOB _____

Cell Phone _____ Home Phone _____ Marital Status _____

Referred by _____ Family Doctor/PCP _____

Insurance _____ ID _____

Patient Email Address _____

HIPPA Privacy & Security rules require your permission to use email as a means of contact.
Please initial next to each if you allow us to use email or text for:
Test results _____ Appointment Reminders _____ Medical Conditions _____

Emergency Contact

Name (Last) _____ (First) _____

Relationship to Patient: _____ Phone _____

Medical Information

Do you have any allergies? Yes No List: _____

Circle if you have ever had:

Asthma Diabetes Poor Blood Clotting Anemia Seizures Stroke Arthritis Kidney Disease Blood Transfusions
High Blood Pressure Cancer Heart Murmur Hepatitis B Hepatitis A

Have you been treated for Hepatitis C in the past? Yes No If **yes**, which medication? _____

Have you been treated for depression or anxiety? Yes No

If applicable: Is there any chance that you may currently be pregnant or are you trying to become pregnant? Yes No

Family History:
Circle if any of your family members have ever had:
Liver Disease Stroke Kidney Disease Cancer Heart Disease Diabetes

Operations or Hospitalizations:

Type of Surgery/Reason for Hospitalizations	Date	Hospital	Comments

Vaccinations & Screenings (check if you have had the following immunizations):

Hepatitis A ☐ Hepatitis B ☐

Have you ever been screened for Hepatitis C? Yes No If yes, when? _____

Have you ever been screened for Hepatitis B? Yes No If yes, when? _____

Have you ever been screened for HIV? Yes No If yes, when? _____

Do you have any risk factors for HIV? (Unprotected sex, multiple sexual partners, IV drug use, etc.)

Are you interested in PrEP medications? Yes No

Have you recently been screened for sexually transmitted infections (STI's)?

Would you like to be screened for sexually transmitted infections? Yes No

Social History:

Do you smoke Cigarettes? Yes No How many per day? _____

How many years? _____ When did you start smoking? _____ If you have quit smoking, when did you quit? _____

Do you drink alcohol? Yes No Daily/Weekly/Monthly Quantity _____

Have you ever used intravenous (IV) drugs? Yes No

Have you ever used nasal (snorting) drugs? Yes No

Current Medications:

Name of Medication	Dosage	Times Per Day	Comments

Authorization to release information and assignment of benefits:

I Authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original and request payment of insurance and benefits to be made to the provider.

_____ _____

Signature Date

I authorize any holder of medical or other Information about me to release to the Social Security Administration and Health Care Financing Administration or its Intermediaries or carriers any information needed for this or related Medicare or insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts the assignment below.

_____ _____

Signature Date

Billing Policy Information

Our office has contracted with various health plans to file for any changes incurred by our Physician(s). However, we request payment at the time of service for those insurance carriers we are not contracted with. In order to fulfill our agreement and obtain all necessary information, we ask that you present your insurance card when signing in for treatment. We will copy your card and maintain it for billing purposes. Although it is your responsibility to be aware of your policy, our office makes every effort to ensure that all are met. Kentucky state law mandates insurance carrier to make a payment within a 30-day time period. If this is not done, you should contact your insurance carrier to find a resolution, as it is a financial obligation to secure payment. By signing below, I am indicating that I fully understand the above statements. Should collection preceding become necessary, I agree to pay all costs of collections, including reasonable attorney's fee and waive all rights to claim personal property exempt under the laws of the state of Kentucky. I hereby assign to and authorize payment directly to Hepatitis C Treatment Center, Inc, Bennet Cecil., Inc, all benefits payable under the terms of any insurance policy listed on this form. I realize the insurance benefits may not pay all the bill and agree to pay the difference to the entire bill if necessary. I authorize the release of any medical information necessary to process claims on any insurance policy listed on this form.

_____ _____

Signature Date

Telemedicine Consent

In order to give patients the greatest availability in our telehealth services the patient is given the option to be seen via our telehealth programs based in our satellite offices. We have locations throughout the state in Campbellsville, Russell Springs, Louisville and Monticello. Our providers work at all of these locations and it would not impact the continuity of care. The patient may see one of our partner hospitals listed on their billing statement. Our partner hospitals accept a wide range of insurances (in some cases--they are able to accept more plans than we can in our main office). Consenting to telehealth services includes consenting to be seen through our satellite offices. Patients are always allowed to physically come into our Louisville office to be seen. Consent for telehealth is not a requirement of receiving care from us, but dates will be limited based on the provider's location and availability. This has been discussed with the patient and the patient has orally confirmed understanding and requested participation in our telehealth program as described above.

Telemedicine services is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners. I understand that my health care providers have offered me the opportunity to utilize telemedicine services as part of my treatment at the Hepatitis C Treatment Center “HCTC.” I voluntarily authorize HCTC and its physicians, practice professionals, and other persons (such as colleagues, physicians-in-training, technical assistants, and other health care providers) to utilize telemedicine as part of my treatment. I agree to participate in a telemedicine evaluation/supervision. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can

be viewed by a doctor and other persons involved in my medical or mental health care. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand there are potential risks with this technology: (1) The video connection may not work or that it may stop working during the consultation. (2) The video picture or information transmitted may not be clear enough to be useful for the consultation. (3) I may be required to go to the location of the consulting physician if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis. I give my consent to be interviewed by the consulting health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

Information gathered from me as part of the telemedicine services may be used for diagnosis, therapy, follow-ups and/or education, and may include, without limitation, the following: (1) medical records (2) medical images (3) live two-way audio and video (4) output data from medical devices and sound/video files (5) electronic communication. I agree that the use of telemedicine services has been explained to me, including purpose, limitations, benefits, anticipated duration, reasonable alternatives, the option to opt out of telemedicine, and the risks of opting out. I understand the following: (1) I have the right to withhold or withdraw my consent to telemedicine without affecting my right to future care/treatment. (2) I have the right to inspect all information obtained and recorded in the course of telemedicine services and may receive copies of this information for a reasonable fee. (3) A variety of alternative methods of medical care may be available to me, and that I may choose one or more of the options of care. (4) Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state. (5) It is my duty to inform my providers of electronic interactions regarding my care that I may have with other providers. (6) My provider and I may discontinue the telemedicine services if it is felt that the videoconferencing is no longer adequate for care. (7) In an emergent consultation, my provider may refer me to my local practitioner and that my provider's responsibility will conclude upon the termination of the remote connection. I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes. Upon completion of virtual services, I authorize HCTC, LLC representatives, to sign on behalf of the responsible adult where a responsible adult/parent/caregiver signature is required for insurance or other payor documentation.

I hereby release HCTC, LLC, its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.

I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the conditions described in this document.

I consent to telemedicine services

_____ _____

Signature Date

I **DO NOT** consent to telemedicine services.

_____ _____

Signature Date

Appeal Agreement

I give permission to Dr. Cecil and office staff to submit authorization requests on my behalf, and if necessary, to appeal the denial of any ordered medications.

_____ _____

Signature Date **THE**

FOLLOWING AUTHORIZATION MUST BE COMPLETED

I AUTHORIZE The Cecil Specialty Clinic to discuss my symptoms, test results and or treatment with the following individuals:

Name	Relationship	Telephone Number

_____ _____

Signature Date

I **DO NOT AUTHORIZE** The Cecil Specialty Clinic to discuss my symptoms, test results and/or treatment with anyone other than myself.

_____ _____

Signature Date

Medical Record Release

The following patient has asked us to request that his/her medical records be released and forwarded to our office.

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your database. Please be sure to include any ultrasounds, CTs/MRIs, x-rays, pathology, or biopsy reports for continuation of care.

_____ _____

Signature Date

Patient Name: _____ _____ _____

(Last) (First) (MI)

Age_____ SSN_____ DOB _____/_____/_____

Street Address _____

City _____ State _____ Zip _____