Lake Cumberland Rheumatology, PLLC

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Phone 606-802-2300
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www.insideLCR.com

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Welcome to Lake Cumberland Rheumatology,

We are honored to assist you in your rheumatology needs. Our goal is to be the best rheumatology practice in Kentucky where we offer compassionate and efficient care. To help your visit, please complete all attached forms **prior to your office visit.** Form may be brought to the office, mailed, faxed 606-802-2400, or emailed at insideLCR@gmail.com

Helpful Tips

You must give a 24 hour notice to cancel an appointment. Please note NO SHOWS will be charged a $50 fee.

Arrive **15 minutes early** with your insurance information, forms, and driver's license/form of ID.

We do not accept any KY ***Medicaid (Wellcare, KY Spirit or Coventry Cares).*** UMR and PHCS plans will be billed at an out of network rate which may result in an increased patient payment responsibility. Please call the number on the back of your card for the out of network rate.

Bring all abnormal labs, MRI reports, information with you. You may need to call your referring doctor.

We provide digital x-ray, ultrasound, lab draws, injections, braces and IV medications at our office for your convenience.

Prescriptions are sent electronically. Future refills should be done by calling your pharmacy who will electronically contact us or by use of the patient portal which you will be set up with during your first visit.

Future contact after your visit should be done via the patient portal as this is the most efficient means of communication with our staff including questions for the doctors, refills, lab/imaging results.

Thank You,

Lake Cumberland Rheumatology Staff

Directions:

Somerset Office

Going north on Route 27 (the main shopping strip through Somerset), turn left at light #10.

Going south on Route 27, turn right at light #10.

T & T motors is located at the light. The street you turn onto is Bogle Street. Coming up the hill toward the hospital on the right, you will turn left onto Hail Knob Road. If you come to a stop sign then you missed it and will need to turn around. After turning on Hail Knob Road you will go 100 yards and then turn left onto Oxford Way. We are the first building on the right, Suite A. If you go past Med Park West on the left, you have gone too far.

OF NOTE GOOGLE AND APPLE MAPS ARE NOT ALWAYS ACCURATE WITH FINDING OXFORD WAY. IF YOU PUT IN THE INTERSECTION OF BOGLE AND HAIL KNOB ROAD THIS WILL GET YOU CLOSE. OXFORD WAY IF OFF OF HAIL KNOB ROAD AND NEXT DOOR TO LAKE CUMBERLAND NEUROSURGERY CLINIC.

LONDON OFFICE

From I 75, take north exit for London (exit 41) turn south on 25 toward downtown London. We are in the Lake Cumberland Foot and Ankle building which is past Sara Lee building. The building is on the same side of the street.

Patient's Name:_____

Age:_____ **Date of Birth:**_____ **Sex: M**____ **F**____

Address:_____

City:_____**State:**_____**Zip Code:** _____ **SS#**_____

Marital Status:_____ Home Phone# _____ Primary Care Physician_____

WE USE A PATIENT PORTAL TO COMMUNICATE YOUR LAB RESULTS, RADIOLOGY RESULTS, QUESTIONS TO NURSES AND ALL STAFF. THIS IS INTERNET BASED AND WE REQUIRE YOUR CELL PHONE AND EMAIL TO BETTER COMMUNICATE WITH YOU.

Cell Phone#_____

Email address (we do not distribute to anyone):_____

Primary Pharmacy (include town)_____

Mailing Pharmacy Company_____

Referring Physician/Provider and other physicians you would you're your information sent to _____

_____

In case of an emergency contact: _____

Emergency Relationship:_____ Phone#:_____

Please list insurance companies you have coverage through below in order of coverage.

1) _____

2) _____

3) _____

Subscriber of Insurance (self/spouse):_____

Date of Birth of Subscriber (if different than yourself)_____

HIPPA Acknowledgment:

Authorization

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. All copays are payable at the time of service.

I hereby authorize Lake Cumberland Rheumatology, PLLC to furnish insurance companies or their representatives information concerning my (my dependents) illness and treatments and I hereby assign to Lake Cumberland Rheumatology, PLLC all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Appointment policy

Please cancel appointments you are unable to keep to assist us in making room for sick patients. Excessive no shows will result in dismissal as determined by this office.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times, financially responsible to Lake Cumberland Rheumatology and/or its affiliated entities for any charges provided not covered by health care benefits. It is my responsibility to notify Lake Cumberland Rheumatology of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Lake Cumberland Rheumatology and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Lake Cumberland Rheumatology, PLLC for all covered medical services and supplies provided during all courses of treatment and care provided by Lake Cumberland Rheumatology, PLLC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continuing effect for so long as treatment or care is through Lake Cumberland Rheumatology, PLLC and will constitute a continuing authorization, maintained on file with Lake Cumberland Rheumatology, PLLC which will authorize and allow for direct payment to Lake Cumberland Rheumatology, PLLC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies, and or care provided to me by Lake Cumberland Rheumatology, PLLC

Authorization to Release Information

I authorize the release of any medical or any other information to the Heal Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided by Lake Cumberland Rheumatology, PLLC. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Lake Cumberland Rheumatology, PLLC.

Effective Date: November 2008

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this information carefully. This notice applies to Lake Cumberland Rheumatology, PLLC, and employee's working at this facility.

Our Legal Duty

We are required by law to protect the privacy of your information. We are providing this notice to you so that we can explain what our privacy practices are. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time.

Complaint

For more information about our privacy practices or to place a complaint or report a concern or conflict, call 606-802-2300

You may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate DHHS address. Under no circumstance will you be retaliated against for filing a complaint.

Notice of Privacy Practices

How your health information may be used.

We may use health information about you for your billing purposes, to obtain payment, or for healthcare operations and other administrative purposes. Examples of each item mentioned above include:

Treatment: We may need to send your medical record information to another specialist or physician as part of referral for continuity of care

Payment: We will use your health information and other identifying information for billing Medicare, Medicaid, or health insurance plans.

Operations or administrative purposes: We use your information when processing your medical records for completeness and to compare patient data to improve our treatment methods.

Patient or Responsible Party certifying that all of the above has been read and understood

HIPAA ACKNOWLEDGEMENT: I have been given the Lake Cumberland Rheumatology, PLLC HIPAA Policy

Signature _____Date_____

I would like _____ to be my Authorized Representative if I am not available.

Dr. Timothy Lonesky DO
Dr. Scott Lewis DO
26 Oxford Way, Suite A
Phone 606-802-2300 Fax 606-802-2400

The below is a request for medical records in case we need to obtain any medical history from you in the future. Please fill in your name, date of birth, and signature only.

Request for Release of Medical Records

To:_____

I hereby authorize you to release my medical records to

Lake Cumberland Rheumatology
230 Tower Circle, Somerset, KY Phone: 606-802-2300 Fax: 606-802-2400

My Name:_____ **Date of Birth** _____

Signature: _____

Information needed (office use)_____

FAMILY HISTORY: Questions done in this format to adhere to Medicare / Insurance Guidelines:

- Unknown Family History
- Adopted

Circle what your family member has

- **Natural Father**: alive/well, deceased, alcoholism, arthritis, anemia, anxiety, cancer, cataracts, diabetes type 1, diabetes type 2, hyperlipidemia, hypertension, kidney disease, stroke, rheumatoid arthritis, lupus, sjogren's syndrome, osteoporosis, psoriasis, psoriatic arthritis, gout, fibromyalgia

- **Natural Mother**: alive/well, deceased, alcoholism, arthritis, anemia, anxiety, cancer, cataracts, diabetes type 1, diabetes type 2, hyperlipidemia, hypertension, kidney disease, stroke, rheumatoid arthritis, lupus, sjogren's syndrome, osteoporosis, psoriasis, psoriatic arthritis, gout, fibromyalgia

- **Natural Bother**: alive/well, deceased, alcoholism, arthritis, anemia, anxiety, cancer, cataracts, diabetes type 1, diabetes type 2, hyperlipidemia, hypertension, kidney disease, stroke rheumatoid arthritis, lupus, sjogren's syndrome, osteoporosis, psoriasis, psoriatic arthritis, gout, fibromyalgia

- **Natural Sister**: alive/well, deceased, alcoholism, arthritis, anemia, anxiety, cancer, cataracts, diabetes type 1, diabetes type 2, hyperlipidemia, hypertension, kidney disease, stroke rheumatoid arthritis, lupus, sjogren's syndrome, osteoporosis, psoriasis, psoriatic arthritis, gout, fibromyalgia

- **Natural Son**: alive/well, deceased, alcoholism, arthritis, anemia, anxiety, cancer, cataracts, diabetes type 1, diabetes type 2, hyperlipidemia, hypertension, kidney disease, stroke rheumatoid arthritis, lupus, sjogren's syndrome, osteoporosis, psoriasis, psoriatic arthritis, gout, fibromyalgia

- **Natural Daughter**: alive/well, deceased, alcoholism, arthritis, anemia, anxiety, cancer, cataracts, diabetes type 1, diabetes type 2, hyperlipidemia, hypertension, kidney disease, stroke rheumatoid arthritis, lupus, sjogren's syndrome, osteoporosis, psoriasis, psoriatic arthritis, gout, fibromyalgia

- **Other family history:**_____

Your Medical History

Disease	Year Started (OK to estimate)	Comments

Surgeries (include arthroscopy and stents)	Year	Surgeon

Are you on disability?_____Applying for disability?_____Lawsuit pending?_____

Occupation:

Most of Life_____

Current_____

If retired what year did you retire _____

Highest education level you finished _____Marital Status_____

Number of children_____

Do you smoke or did you smoke? Yes or No

If yes how many years _____If you quit, when_____

Do you use smokeless tobacco or did you use smokeless tobacco? Yes or No

Do you drink alcohol? Yes or No If yes, how much do you drink weekly_____

Did you used to drink alcohol heavily? Yes or No If yes, when did you stop_____

Do you use illicit drugs or have you used illicit drugs? Yes or No

Do you exercise regularly? Yes or No If yes, what do you do_____

Please in one sentence describe the problem or symptoms for you seeing a rheumatologist?

_____

_____

_____

_____

Body region of symptoms:_____

Circle quality of symptoms: Achy Stiff Throbbing Burning Tingling Sharp Dull

How long have you had these symptoms:_____

Diagnosis given _____

Physicians or practitioners seen for this issue: **_____**

Previous treatments (include physical therapy, surgery, injections)

_____

_____

Previous studies done to evaluate (MRI/x-rays/labs) please include approximate date of studies and if you have access to these, please bring them to your visit

_____

_____

_____

Do you use any assistance devices (walker, cane, brace)?_____

Drug Allergies (please include side effect)

_____

_____

_____

Primary Pharmacy (include town)_____

Mailing Pharmacy Company_____

Current medication list. If you have it written already, please give us a copy.

Medication Name	Dose	How many time per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please circle if you have used any of the below medications.

ANTI-INFLAMMATORY: **A**rthrotec (diclofenac) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Naproxen

PAIN: Hydrocodone Oxycodone Ultram (tramadol) Other pain medications_____

FIBROMYALGIA: Lyrica Cymbalta Savella Elavil (amitriptyline) Flexeril Neurontin (gabapentin) Others_____

RHEUMATOID: Plaquenil (hydroxychloroquine) Methotrexate Azathioprine (imuran) Sulfasalazine Leflunomide (Arava) Enbrel Humira Remicade Actemra Rituxan Cimzia Simponi Orencia Xeljanz Prednisone Medrol Others_____

OSTEOPOROSIS: Alendronate (fosamax) Raloxifene (Evista) Calcitonin Risedronate (Actonel) Boniva Reclast (IV yearly) Prolia Calcium/D Others_____

GOUT: Allopurinol Febuxostat (Ulori) Colchicine(colcrys) Probenecid

THIS IS A STANDARDIZED FORM USED IN RHEUMATOLOGY. YOU MUST FILL THIS OUT.

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including shoelaces and buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car or vehicle?	0	1	2	3
i. Walk two miles, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

How much pain have you had because of your condition OVER THE PAST WEEK?

NO PAIN 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 **AS BAD AS IT COULD BE**

With all the ways in which health conditions may affect you at this time, how you are doing:

VERY WELL 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 **VERY POORLY**

Please check (√) if you have experienced any of the following over the last month:

__Fever	__Loss of appetite	__Skin rash or hives
__Weight gain (>10 lbs.)	__Trouble swallowing	__Rash in the sun
__Weight loss (<10 lbs.)	__Heartburn	__Loss of hair
__Feeling ill or sickly	__Stomach pain or cramps	__Headaches
__Dry eyes	__Nausea or Vomiting	__Dizziness
__Change in vision	__Constipation or persistent diarrhea	__Losing your balance
__Red/painful eyes	__Dark or bloody stools	__Numbness or tingling of arms or legs
__Problems with hearing	__Problems with urination	__Fainting spells
__Ringing in the ears	__Gynecological (female) problems	__Depression - feeling blue
__Stuffy nose	__Sexual problems	__Anxiety - feeling nervous
__Sores in the mouth	__Burning in sex organs	__Problems with thinking
__Dry mouth	__Muscle pain, aches, or cramps	__Problems with memory
__Problems with smell or taste	__Muscle weakness	__Problems with sleeping
__Lump in your throat	__Swelling of hands	__Unusual fatigue
__Pain in the chest	__Swelling of ankles	__Swollen glands
__Heart pounding (palpitations)	__Swelling in other joints	__Unusual bruising or bleeding
__Cough	__Joint pain	__Use of drugs not sold in stores
__Shortness of breath	__Back pain	__Smoking cigarettes
__Wheezing	__Neck pain	__More than 2 alcoholic drinks per day
__Fingers turn blue in color		__Problems with social activities

( ) I would appreciate prayer from my provider. Physician and staff will pray for you at the end of the day.

Thank you for completing these forms which will improve your medical care. We look forward to meeting you.

INSURANCE INFORMATION

- **If you have insurance, your benefits have already been verified with our office, so be prepared to pay any copays, or deductibles that have not been met, or coinsurances that is due. We figure your total due according to the information received by your insurance company. If for some reason you are unable to pay the total amount expected of you, please speak with our Collections department and arrange some type of payment plan.**

- **If you do NOT have insurance, be prepared to implement a payment plan before leaving our office at the end of your visit. We work with CareCredit finance to make sure you can arrange a payment plan that will fit your financial situation.**