Pendleton Family Care, LLC
1412 North Race St.
Glasgow, KY 42141
270.629.6333 (office)
270.629.6334 (fax)
www.pendletonfamilycare.com

Dear Valued Patient,

Welcome to our practice! We are so glad you have elected to visit us!

Pendleton Family Care, LLC is dedicated to providing our patients with the best care available. Enclosed you will find our new patient information packet, office policies, and other pertinent information.

Before your scheduled appointment, please carefully read and complete the enclosed "New Patient Registration Packet," along with all other pertinent information listed below within this letter. Be sure to bring these forms with you to your scheduled appointment. ***We ask that you arrive 15 minutes prior to your scheduled appointment time to allow for our staff to register you in our system and complete any additional documents that may be necessary.***

At the time of your appointment, you will need the following:

- Your insurance card(s), driver's license, and social security card. (Initial visit)
- Any lab tests, medical records, X-Rays pertinent to why you are being seen by our provider. (Initial visit)
- A complete list of any or all prescriptions, over the counter, and herbal medications that you are currently taking. (Each visit, we will make you a medication card for your convenience if requested)
- Payment for any applicable copayment, deductible, and/or coinsurance responsibility. We gladly accept VISA, MasterCard, Discover, and American Express credit cards. We also accept check and cash payments. (Payments are due at each visit)

If you cannot keep your appointment for any reason, please contact our office as soon as possible so that we may reschedule your appointment.

Again, we thank you for choosing Pendleton Family Care, LLC, for your medical care. Please feel free to contact us anytime with your questions or concerns, our contact information is located on the above right corner of this page.

Sincerely,

The Staff at Pendleton Family Care, LLC

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New Patient Registration Packet

Please advise our staff if you or anyone in your family has any special accommodation needs, we will be happy to make proper arrangements.

Patient Information:

Name: _____ Social Security Number: _____-_____-_____ Date of Birth:_____ Sex: F M

Marital Status: (circle) Single Married Divorced Separated Widow(er)
Ethnicity: (circle) Caucasian African American Hispanic Other: _____ Language: (circle) English Spanish Other:_____
Mailing/Billing Address: _____City/State/Zip: _____
Employer: _____Occupation:_____

Home: (___) _____Cell: (___) _____Work:(____) _____What is method to to reach you? _____

How did you hear about our practice? _____

For Pendleton Family Care Patient Portal Use (online access to request appointments, make medication requests, refills, receives lab results, contact staff for general non emergent message(s) etc. Terms and conditions for use are posted on our practice website or available by request.
Email Address: _____

Emergency Contact Information:

(Used only if unable to reach you. Please note that no health information will be shared)

Name: _____ Phone:(___) _____ Relationship to Patient: _____

Parent/Legal Guardian Information:

(If patient is a minor, (under 18) or over 18 and unable to make decision for him/herself)

Name of Parent/Guardian 1: _____
Street Address: _____City, State, Zip:_____
Mailing Address: _____City, State, Zip:_____
Relation to patient: _____
Best Phone # to reach you: (____) _____

Name of Parent/Guardian 2: _____
Street Address: _____City, State, Zip:_____
Mailing Address: _____City, State, Zip:____
Relation to patient: _____
Best Phone # to reach you: (____) _____

(Please provide a copy or relevant court documents if you claim sole legal custody of a minor or are the legal guardian for patient over 18.)

Insurance Information:

Primary Insurance Name: _____ **Secondary** Insurance Name: _____
Group Number: _____ ID Number: _____ Group Number: _____ ID Number: _____

Name of Subscriber: _____ Name of Subscriber: _____
Subscribers address: _____ Subscribers address: _____
(If different from patients) *(If different from patients)*
Subscribers Date of Birth: _____ Subscribers Date of Birth: _____
Relationship to Patient: _____Relationship to Patient: _____

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Fax Authorization Request for Medical Records to be sent:

(Please note if you do not wish for Pendleton Family Care, LLC to request a copy of your medical records for the past year from your previous primary care provider you may leave this page blank)

Please list the Medical Provider/Hospital in which you would like us to request a copy of your medical records:

_____

I agree that this authorization to release records will be as valid on a faxed copy or photocopy as it is on the signed original.

Please release the following records to Pendleton Family Care, LLC:

_____ All medical Records and Medical Summary/Progress Notes
_____ Labs and Diagnostic Imaging Reports (X-Rays, Dexa, Mammo, U/S, CT, MRI, PET)
_____ Consult/Operative Notes
_____ Complete Hospital Records (ER Records, Discharge Summaries, Inpatient Stay Records, All Diagnostic Results)

_____ Psychiatric Records

_____ _____
Printed Name of Patient/Legal Guardian Patient Date of Birth

_____ _____
Signature of Patient/ Legal Guardian Date

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Electronic Medical Records System:

We maintain many medical records through a computer database. This system is structured to maintain the privacy of your records in accordance with applicable laws, while allowing access to your records by your other health care providers who utilize the system. Once we entered medical records on the system, if you seek care from another provider who utilizes the same system, the other healthcare provider may access medical records relating to your treatment here as appropriate to provide you with ongoing care. However, if they do not use the same medical software as us here at Pendleton Family Care, LLC you may sign consent to allow us to send any information to the consulting provider(s) they may need to help us care for you.

Insurance Authorization and Assignments of Benefits:

While we participate with many national healthcare/insurance plans, if we do not participate with your insurance carried, you will be billed as a self-pay patient and be responsible for the entire balance for all services rendered. If we participate with your insurance, you will be responsible for any co-payments and/or deductibles at the time the services are rendered. We accept debit, credit, cash and check; however, we must charge a $50 fee for any returned check. In an effort to help ensure accurate insurance billing, we ask that you present your insurance card and a photo ID at each visit. Acceptable forms of payment are cash, check, debit and all major credit cards.

Consent to Contact

I acknowledge and agree that Pendleton Family Care, LLC and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, 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, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Pendleton Family Care, LLC, if I have given up ownership or control of any such telephone number.

Collections

While copays, deductibles and co-insurance are due at the time of service there are times that after insurance processes your claims there will still be an amount due from you. We will bill you for any remaining balance due. If you fail to pay your balance promptly and your account is placed with an outside collections agency you will be responsible for any cost incurred to collect any balance due with our office.

Joint Notice of Privacy Practices-Health Insurance Portability and Accountability Act (HIPPA:

I have received/was offered a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed and explains my rights as a patient. I understand that I should read this document carefully and that it may be changed at any time. I may obtain a copy of the Joint Notice by calling the practices. This practice uses an electronic medical record that maybe be shared with other provider specialties and/or hospitals. I consent to evaluation and treatment by any provider affiliated with Pendleton Family Care. I hereby authorized release.

_____ _____
Printed Name of Patient/Legal Guardian Patient Date of Birth

_____ _____
Signature of Patient/ Legal Guardian Date

Permission for Health Care Providers to Discuss my Health care with family members/friends:

(Please note: If you do not want Pendleton Family Care, LLC to discuss your health care with anyone you may leave this section blank.)

I allow my treating healthcare provides to discuss my health care with the individual(s) names below. These individuals play some role in my care, either by assisting me directly or by offering support to me and my other family members.

_____ _____ (___)_____
Printed Name of Individual Authorized to Receive Information | Relationship | Phone Number

_____ _____
Printed Name of Patient/Legal Guardian Date of Birth

_____ _____
Signature of Patient/Legal Guardian Today's Date

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Past Medical History:

Health Maintenance: (Both Men and Women)

Last Visual Exam: _____
Last Dental Exam: _____
Last Hearing Exam:_____
Last Mammogram: _____
Last Self Breast Exam: _____
Last PAP: _____
Last Testicular Exam: _____
Last Self Testicular Exam:_____
Last Colonoscopy:_____
Last Rectal Exam:_____
Last Dexa Scan: _____

Alcohol/Caffeine/Tobacco Use:

Weekly Amt of Alcohol:_____
Daily Amt of Caffeine:_____
Tobacco use: Y or N

List any other provider(s)/specialist(s) you see:

_____
_____
_____
_____

Preferred Pharmacy:

_____

Current Medical History:

_____
_____
_____
_____
_____
_____

Surgical History:

Surgery: Date:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug/Food Allergies:

_____
_____
_____
_____
_____
_____

Current Medications:

Check box if None ☐
List:
Name: Dose: How Often:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Condition	Mother	Father	Sibling	Maternal GP	Paternal GP
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

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Control Substance Agreement Form

I, _____, a patient of Michael Pendleton Sr., APRN, FNP-BC/Pendleton Family Care, LLC, have been informed that individuals who are prescribed certain controlled substances including, but not limited to narcotic pain medicines, stimulants, benzodiazepines, tranquilizers and barbiturate sedative, can abuse those substances or may allow abuse by others and have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. Therefore, I have been informed that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as condition of, the willingness of the provider whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat my condition(s).

1) I will inform my provider of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
2) I agree that I may be subject to voluntary evaluation by psychologists and/or psychiatrists, possibly at my own expense, before any controlled substance will be prescribed to me. I agree that the need to be evaluated by psychologist and/or psychiatrist or pain, or other specialist may be revisited everyone (1), three (3), to six (6) months thereafter while taking the medication, or as suggested by that provider.
3) All my controlled substances must come from a provider in Pendleton Family Care, LLC. My controlled substance will come from the provider whose signature appears below, or during his absence by the covering provider, unless specific written authorization is obtained from the office for an exception.
4) I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform Pendleton Family Care, LLC.
5) I will inform Pendleton Family Care, LLC office of any new medications or medical conditions and of any adverse effects I experience from any of the medications that I take, whether prescribed from this office or not.
6) I will inform all of my other health care providers that I am taking the controlled substance(s) prescribed and of the existence of this Agreement. In the event of an emergency, I, or someone on my behalf, will provide the foregoing information to emergency department providers.
7) I agree that my prescribing provider has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
8) I will not allow anyone else to have, use, sell or otherwise have access to these medications. <u>The sharing of medications with anyone is absolutely forbidden and against the law.</u>
9) I understand that controlled substances may be hazardous or lethal to a person who is not tolerant of their effects, especially a child or the elderly and I must keep them out of reach of such people for their own safety.
10) I understand that tampering with a prescription is a felony and I will not change or tamper with any of my provider's prescriptions.
11) I am aware that attempting to obtain any controlled substances prescription under false pretenses is illegal.
12) I agree not to alter my medications in any way, and I will take my medication whole, and it will not be broken, (unless directed per prescriptions directions) chewed, crushed, injected or snorted.
13) I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by Michael L. Pendleton Sr., APRN, FNP-BC or the provider on duty at Pendleton Family Care, LLC.
    I understand that these drugs should not be stopped abruptly, as withdrawal symptoms may develop.
14) I will cooperate with unannounced urine or serum toxicology screenings as they may be requested, as well as any random pill counting's of my medication. If I am called in for a random supervised urine screen and/or pill counting, I understand I will have two (2) hours and/or by the end of office hours to comply once being called. Failure to comply may result in my immediate discharge.
15) I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt to my referral for assessment for a substance abuse disorder or discharge from the practice.

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16) I understand that medications may not be replaced if they are lost, damaged, or stolen. IF any of these situations arise that cause me to request an early refill or my medication, a copy of a filed police report or statement from me explaining the circumstance may be required before additional prescriptions are considered. If I request an early refill secondary to lost, damaged, or stolen prescriptions twice within a year, I may be discharged.
17) I understand that a prescription may be given early if the provider or the patient will be out town when the refill is due. These prescriptions will contain instructions to the pharmacists that the prescription(s) may not be filled prior to the appropriate date.
18) If the responsible legal authorities have questions concerning my treatment, as may occur for example, if I obtained medications at several pharmacies, all confidentiality is waived and the authorities may be given full access to my fill records of controlled substances.
19) I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so at a minimum of twenty-four (24) hours before it is scheduled. I will update office of any changes to address or telephone number promptly in order for them to contact me if needed.
20) I understand that I may be asked to bring my medications in their original container to the office while I am on controlled medications.
21) Refills generally will not be given over the phone, after office hours, during the weekends or holidays.
22) I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy and continued prescription is contingent on whether my provider believes that the medication usage benefits me. I will comply with all treatments as outlined by my provider at all times.
23) I have been explained the risks and potential benefits of these therapies, including but not limited to, psychological addiction, physical dependence, withdrawal, and over dosage.
24) I understand that failure to adhere to these policies and/or failure to comply with the providers treatment plan may result in cessation of therapy with controlled substance prescribing by this office or referral for further specialty assessment, as well as, possible discharge from the practice in general.

I, the undersigned patient, attest that the foregoing was discussed with me and that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and will be would by this Agreement in its entreaty until termination of this agreement.

By signing below I attest that I am of sound mind and am legally able to sign for myself or as the representative of the patient. I understand all documentation and have had all, if any questions fully answered by the staff at Pendleton Family Care, LLC before signing this document. I further state that all information is true and accurate to the best of my knowledge at the time this form was completed. Also, that I fully understand misrepresentative of such said information is considered fraud, is against the law, and will be punished to the full extent of the law accordingly.

_____	_____
Printed Name of Patient/Legal Guardian	Date of Birth
_____	_____
Signature of Patient/Legal Guardian	Today's Date
_____	_____
Printed Name of Witness	Signature of Witness
_____	_____
Printed Name of Provider	Signature of Provider