BLUEGRASS
DIRECT PRIMARY CARE

Patient Information

Last Name _____ First Name _____ MI _____

Gender M ☐ F ☐ DOB _____ SSN _____

Marital Status S ☐ M ☐ W ☐ D ☐ Race _____

Address _____

Community Name_____ Apt/Room # _____ City _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____ Preferred Pharmacy _____

Pharmacy Phone # _____ Pharmacy Address _____

Responsible Party (If not the patient, must have copies of legal documents on file)

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext. _____ **Email** _____

Relationship to Patient? _____ Medical POA? Y ☐ N ☐ Financial POA? Y ☐ N ☐

Emergency Contact

Last Name _____ First Name _____ MI _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext. _____ Email _____

Relationship to Patient? _____

Primary Insurance Policy

Provider _____ Policy/Subscriber ID_____ Group No. _____

Secondary Insurance Policy

Provider _____ Policy/Subscriber ID_____ Group No. _____

Does Patient have Medicaid? Y ☐ N ☐ ID# _____

How did you find out about us? _____

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Medical History Form

Advanced Directive

- ☐ DNR (Do not resuscitate)
- ☐ Full Code

Current Medical Problems

_____
_____
_____
_____
_____

Past Medical Problems

_____
_____
_____
_____

In the past year, have you been hospitalized? If so, when, where and why?

_____
_____
_____

Please list any surgeries and dates.

_____
_____
_____

Please list allergies including medications.

_____
_____

Please provide a complete list of medications, including over the counter medications and vitamins (use a separate list if needed). Please include dosage amounts and frequency. _____
_____
_____
_____
_____
_____

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Medical History Form

Where were you born? _____ Height? _____ft _____in Weight? _____lbs

Highest level of education? _____

Occupation? _____ Are you employed or retired? _____

Do you have children? _____ How many? _____

Any grandchildren? _____ How many? _____

Who resides in your home? _____

Hobbies _____

Do you:

Exercise regularly? Y ☐ N ☐ Drink alcohol? Occasionally ☐ Socially ☐ Often ☐ Heavily ☐

Use recreational or illicit drugs? Y ☐ N ☐ If yes, what? _____

Smoke? Y ☐ N ☐ Quit ☐ If yes, how many years have you smoked? _____ How many packs per day? _____

Use smokeless tobacco? Y ☐ N ☐ Vape? Y ☐ N ☐

Have hearing aids? Y ☐ N ☐ Have false teeth or dentures? Y ☐ N ☐ Wear glasses? Y ☐ N ☐

Wear only reading glasses? Y ☐ N ☐ Wear contacts? Y ☐ N ☐

Date of your last vaccinations:

Flu _____ Pneumonia _____ Shingles _____

Covid-19 Dose 1_____ Covid-19 Dose 2_____ Covid-19 Booster_____

Date of your last screenings:

Mammogram _____ PAP Smear _____ Colonoscopy _____

Family Medical History

Please check the initial for each relative type that has the below issues. M=Mother F=Father B=Brother S=Sister C=Child

Diabetes M☐ F☐ B☐ S☐ C☐

High Blood Pressure M☐ F☐ B☐ S☐ C☐

Cancer M☐ F☐ B☐ S☐ C☐

Seizures M☐ F☐ B☐ S☐ C☐

Mental Illness M☐ F☐ B☐ S☐ C☐

Heart Disease M☐ F☐ B☐ S☐ C☐

Stroke M☐ F☐ B☐ S☐ C☐

Asthma M☐ F☐ B☐ S☐ C☐

Bleeding Problems M☐ F☐ B☐ S☐ C☐

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Patient's Name (printed) _____

Patient's Date of Birth _____

Authorization of Treatment

_____ I authorize the release of my medical records to Bluegrass Direct Primary Care upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments form the past two years.
_____ I authorize payment of my medical benefits to Bluegrass Direct Primary Care for services rendered
_____ I authorize disclosure of my medical record to Bluegrass Direct Primary Care's business associates.
_____ I authorize Bluegrass Direct Primary Care to give my insurance company any information about services rendered to me necessary to process claims.
_____ I acknowledge that I received the practice's Notice of Privacy Practices describing the use and disclosure of confidential healthcare information, also available at https://bluegrassdirectprimarycare.com/hipaa-privacy-practices
_____ I understand and agree that I am financially responsible for all charges for service rendered to me, including balances owed after insurance payments.

Signature _____ Date_____
Printed Name of Person Completing this Form _____
Relationship to Patient _____
***If signing as a POA, please include a copy of the power of attorney.**

Advanced Beneficiary Notice (ABN)

NOTE: If Medicare doesn't pay for the services below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for services below.
WHAT YOU NEED TO DO NOW: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading this document. Choose an option below about whether to receive the items listed below.
Trip Charge: This fee compensates for our travel time, the lost income or "opportunity cost" associated with seeing patients at their home instead of the physician's office. This fee is not covered by any insurance and is due upon the arrival of the provider.

Urgent Visit Trip Fee -(after 4pm, weekends, holidays)	**$150 (Not a covered benefit)**	*****$100 FEE FOR "NO SHOW" HOME VISITS*****
Urgent Nurse Visit Trip Fee -(after 4pm, weekends, holidays)	**$100 (Not a covered benefit)**	
After Hours Teleservices -(after 4pm, weekends, holidays)	**$40 (Not a covered benefit)**	
PPD Skin testing and screening	**$45 (Not a covered benefit)**	

Please choose only one:
1) ☐ I want the services listed above when applicable to my care except those I crossed out. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
2) ☐ I want the services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
3) ☐ I don't want the services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

Signature _____ Date_____
Printed Name of Person Completing this Form _____
Relationship to Patient _____

Release of Information Authorization

I authorize the following person(s) to obtain my medical information, pick up prescriptions, and speak to HCMD regarding my care.

Name _____ Relationship _____
Name _____ Relationship _____

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DIRECT PRIMARY CARE

Authorization for Release of Protected Health Information

Patient's Name _____

Patient's Date of Birth _____/_____/_____ Patient's SSN _____-_____-_____

Name of Person Completing this Form _____

Relationship to Patient _____ Source of Legal Authority _____

☐ I hereby authorize Bluegrass Direct Primary Care to disclose and receive protected health information (PHI) as deemed below. Send Health records/information to:

Bluegrass Direct Primary Care
227 E. Main Street, Georgetown, KY 40324
Phone # 859-710-6300 Fax # 833-471-5608

___ I wish to have the following records copied, and I will pick them up at your facility

___ I request the facility copy the following records and fax/send them to the above address

I request the release of all medical records created between _____ and _____

Legal Authority:

___ I am the Patient noted above

___ I am the Patient's legal representative

___ I am the Patient's Power of Attorney

___ I am the Patient's legal Guardian Requestor's Initials _____

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
If signing as a POA, please include a copy of the documentation, as some providers will not release records without the additional documentation.

Signature _____ Date _____

Relationship to Patient _____

BLUEGRASS
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We are excited to offer Care Management support through our new Chronic Care Management program. This support is available to Medicare patients with two or more chronic conditions.

Support

- You will be assigned a personal Care Manager who will maintain contact with you throughout the month to assist with all of your care coordination needs.
- You and your Care Manager will create a Care Plan to help manage your goals.
- Your Care Manager will assist with appointments, medication refills, referrals for treatment, referrals for resources and overall communication between you and your physicians.

DISCLOSURES:

Availability of Services and Cost Sharing: As a Medicare beneficiary you are eligible to receive Care Management support through our Chronic Care Management program. Medicare covers 80% of these services with a 20% copay. Most secondary insurances cover all or part of the 20% copay. If your secondary does not cover the copay, you may be responsible for the copayment.

Supervising Physician: Only one physician can provide Chronic Care Management support to a patient at a time. If you receive a call from another physician's office offering these services, please let them know you are already receiving them from us.

Eligible Conditions: Two or more chronic medical conditions that are expected to last at least 12-months.

Sharing Information: Your Care Plan can be shared at your request.

Canceling Services: Chronic Care Management is a voluntary program. If you consent to receive services, you can cancel services at any time by calling our office.

☐ **I consent to CCM services**

Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

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Dr. Colton Jayne, M.D.

Dr. Jayne is a board-certified Family Medicine Physician. He is highly skilled, an excellent listener, and dedicated to the health of his patients with over 10 years of experience practicing in South Carolina and Kentucky. Dr. Jayne also has specialized training in Sports medicine and Geriatric medicine. Before pursuing a career in medicine, Dr. Jayne earned her Bachelor of Science in Geology from the University of Kentucky. He then worked in the coal and natural gas industry in Eastern Kentucky. He went back to Lexington to attend the University of Kentucky College of Medicine, where he obtained his Medical Degree. Following medical education, he completed a rigorous Family Medicine residency program at the Medical University of South Carolina. Dr. Jayne and his wife Dr. Kristina Jayne (Pediatrician) moved back to Kentucky when they had their first son Ezra. They both feel incredibly privileged to serve as a Physicians in their home state of Kentucky. Over the past few years, Dr. Jayne has added medical expertise to his aesthetic practice. He enjoys incorporating the latest techniques and treatments into his practice. If you are looking for a physician who will invest time in understanding your unique goals and concerns, he is ready to collaborate with you on your wellness journey.

Channa Arnett, FNP-C

Channa brings a wealth of expertise to our Georgetown, KY practice. She started her medical service close to her hometown of Salyersville, KY as an ICU nurse for many years before pursuing advanced education at Frontier Nursing University. This solidified her commitment to providing top-notch healthcare to her patients. In addition to her advanced nursing qualifications, she is certified through the Kentucky Board of Nursing, ensuring that she meets the highest professional standards. Her educational journey also includes a Bachelor of Science in Nursing from Eastern Kentucky University, further reinforcing her strong foundation in nursing and patient care.
Channa is here to meet your medical needs with the utmost care and expertise. She embodies the spirit of our team, which is committed to creating a welcoming and comfortable environment for our valued patients.