STERLING HEALTH CARE

236 W. Main Street
Mount Sterling, Kentucky 40353
P 859.404.7686 | F 859.498.8160

Memorandum of Understanding

Dated: ____6/1/2025_____

Between Sterling Health Solutions (SHS) and Powell County Board of Education.

This Memorandum of Understanding (MOU) sets for the terms and understanding between SHS and

Powell County Board of Education.

Background

_____ will send employees to SHS to perform:

☐ $95.00 – CL/DOT Physical

Purpose

To provide services required by the Department of Transportation for Powell County Board of Education.

Funding

_____ requires Sterling Health Solutions to bill all charges to

__Powell County Board of Education_____ (Name of Company)

__PO Box 430_____ (Mailing Address)

__Stanton, KY 40380_____ (City, State, and ZIP

__606-663-3300_____ (Billing contact phone number)

__606-663-3303_____ (Billing Fax number)

Employee Eligibility

An employee of the organization must bring a signed referral form from employer (see attached). This form will serve to verify eligibility and authorize SHS to bill the organization. If the employee fails to bring in a signed referral form, employee is expected to pay for services at the time of service. No discount will apply under this circumstance. Prior medical information may need to be obtained prior to the examination.

Duration

This will remain in effect from 6/1/2025 to 5/31/2027.

Contact Information

Sterling Health Solutions, Inc.
Dawn Craft
Billing Manager
236 W. Main Street, Mt Sterling, KY 40353
(859) 404-7686 Ext. 529
dcraft@sterlinghealthky.org

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CDL Scheduling Procedure

Please note the following process for scheduling CDL/DOT physicals who are not established patients of Sterling Health Care:

1. The employee completes new patient PAPER packet along with the eligibility form from the company (both attached) and turn into organization.
2. Provider will review form to see what records need to be requested from their current doctor.
3. Patient signs a release of information to get records provider needs/wants to review. (attached)
4. Appointment is scheduled at least 5 business days out with the understanding if we do not receive all records needed for the appointment it will be rescheduled.
5. Provider completes the exam.

By signing below, you are confirming and acknowledging the CDL/DOT Scheduling Procedure for Sterling Health and that you fully understand the process of scheduling a CDL/DOT Physical on behalf of the organization.

Powell County Board of Education (Company Name)

_____ (Authorized signer Printed)

_____ Date:_____
(Authorized Signature)

_____ Date: _____
Tina Bryant, Sterling Health Solutions, Inc. CEO

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Employer CDL Physical Eligibility Form

_____ confirms that _____ is an employee of the organization.
Name of organization Full name of Employee

Sterling Health Solutions will invoice the employer of this employee at the negotiated price for CDL physicals.

_____ (company Name)

_____ (Authorized signer Printed)

_____ (Authorized Signature)

_____ Date:

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STERLING HEALTH SOLUTIONS

To speed up the check in process, please fill in ALL information

Please check the site where you are wanting to be seen:

☐ ***Sterling Health Care (Mt. Sterling)*** ☐ ***SHC-Stanton*** ☐ ***SHC-Owingsville*** ☐ ***SHC-Carlisle***
☐ ***SHC-Paris*** ☐ ***SHC-Winchester*** ☐ ***SHC-School Based Health Services***

Last Name: _____**First Name**:_____**Middle Name:** _____

Nickname:_____**SSN:**_____**Birth Date:**_____

Gender Identity:
□Male □Female

Marital Status: □Divorced □Married □Separated □Single □Unknown □Widow

Race: □American Indian/Alaskan Native □Asian □Black/African American □Native Hawaiian □White □ Other

Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino

Preferred Language: □English □Spanish □Interpreter Needed

Mailing Address:_____ **Zip Code**:_____

Home Phone: _____ **Cell Phone:** _____**Work Phone:** _____

Email Address: _____**Preferred Communication**: Phone/Email

Preferred Phone Contact: □Home □Cell □Work

Living Arrangements □ Alone □Family □Institution □Relative □Roommates □Spouse Only

Living Situation □ Homeless □Transitional □Doubling Up □Street □Other □Unknown □Not Homeless

Agricultural Worker □ Migrant □Seasonal **Are you a Veteran** □Yes □No

Who is/was your Primary Care Provider? _____

Reason for transferring care, if transferring care _____

In case of Emergency, please contact:

Name_____ **Phone:** _____**Relation:**_____

Address_____

Pharmacy: _____

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INSURANCE INFORMATION:

Primary Insurance: _____ **ID#**_____ **GROUP#**_____

Secondary Insurance: _____ID#_____ GROUP#_____

Subscriber Name:_____**Subscriber Date of Birth**_____

Subscriber Gender:____**Subscriber Phone**_____

Subscriber Address if different from Patient:_____

EMPLOYMENT INFORMATION

□Full-time □Part-time □Unemployed □Full-time Student □Part-time Student
□Retired □Unknown □Active Military Duty

Employer Name: _____ **Employer Phone**:_____

Employer Address: _____

HOUSEHOLD INCOME INFORMATION

What is your annual household income? **How many people are in your household?** _____

□No income □Less than 24,999 □25,000 to 39,999 □40,000 to 59,999 □60,000 to 99,999
□100,000 or more

MEDICAL INFORMATION

Please list any medical conditions that you are currently being treated for:

_____

_____

ALLERGIES

Medications	
Vaccines	
Food	
Other	

Serious injuries or accidents:

_____

Please list any operations you have had:

Year occurred	**Operation / Surgery**

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Please list other doctors you see and why you see them:

Provider / Doctor	Condition / Reason you see them

Do you require treatment/medication for chronic pain? ☐Yes ☐No

How were you referred to Sterling Health? _____

Have you ever had a heart catheterization? ☐Yes ☐No If so, when? _____

Have you ever had any arterial stents placed? ☐Yes ☐No If so, when? _____

Have you ever had a colonoscopy? ☐Yes ☐No If so, when?_____ Facility?_____

IMMMUNIZATION HISTORY

Please indicate the date of the following vaccinations:

Vaccination	Date of Immunization
Influenza (flu)	
Pneumonia	
Tetanus/Tdap	
Hepatitis B	
Hepatitis A	
Shingles	

FOR FEMALES ONLY

Are you pregnant or could you be? ☐Yes ☐No Date of last menstrual period_____

Have you had a hysterectomy? ☐Yes ☐No If yes, when_____ Where? _____ Why?__

Was it a total? ☐Yes ☐No Were ovaries removed? ☐Yes ☐No

Do you regularly have a PAP smear? ☐Yes ☐No Date of last test_____ Facility? _____

Do you regularly have a mammogram? ☐Yes ☐No Date of last test_____ Facility? _____

How many children born alive? _____ How many miscarriages? _____

How many stillbirths? _____ How many Cesarean operations? _____

How many premature births? _____ Any complications of pregnancy? _____

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FAMILY HISTORY

Please list Health Conditions experienced by relatives (mark only those that apply):

Condition	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)	**Condition**	**Which Relative** (Mom, Dad, Grandparent, Aunt, Uncle, Brother, Sister, etc)
Heart Attack	Age:	Colitis	
High Blood Pressure		Crohn's Disease	
Congestive Heart Failure		Colon Polyps	
Rheumatic Heart Disease		Hepatitis	
Congenital Heart Disease		Stomach Ulcer	
Breast Cancer	Age:	Kidney Disease	
Colon Cancer	Age:	Stroke	
Leukemia		Migraine	
Melanoma (skin cancer)		Seizures	
Ovarian Cancer		Diabetes	
Pancreatic Cancer		Goiter	
Any other Cancer		Bleeding Tendency	
Asthma		Suicide	
Tuberculosis		Mental Illness	
Other		Drug Abuse	
		Alcohol Abuse	

PERSONAL HABITS

Do you Smoke? ☐Yes ☐No What do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars

How long have you smoked? _____ How many packs per day? _____

Have you regularly smoked in the past? ☐Yes ☐No When did you quit? _____

Have you ever used recreational drugs? ☐Yes ☐No When? _____ What? _____

Do you regularly drink alcohol? ☐Yes ☐No

Beer: Number of bottles or cans per day_____

Wine: Number of glasses per day_____

Liquor: Number of ounces per day_____

Have you had 6 or more drinks of alcohol during a drinking session in the past year? ☐Yes ☐No

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Have you had more than one sexual partner in the last 24 months? ☐Yes ☐No

Has the person you live with hit you or hurt you physically in the past? ☐Yes ☐No

Has any person verbally abused you? ☐Yes ☐No

Is there anything further you think we need to know about you? If so, please explain in the space provided below.

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:_____**

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Please bring all medications to your first visit and all follow up visits. If medications are not provided your appointment may be rescheduled.

Please list ALL medications:

Medication	Dosage/Strength	Frequency/Doses per day

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Authorization for Release of Information

The undersigned hereby authorizes:

Sterling Health Solutions
Sterling Health Care
633 Maysville Rd.
Mount Sterling, KY 40353
Ph: (859)404-7686
Fax: (859) 498-8160

to release to _____
(OR)
procure from _____

_____

Information from the below listed patient/clinic record:

Patient Name: _____ **Patient DOB:** _____
Reason for Request:
__Personal Interest __Continuity of Care __Transferring Care __Social Security/Disability Claim
__Legal Proceedings __Insurance Claims Processing __Other: _____

Date(s) of Service(s) to be released: _____

Medical Records:
I authorize the following information to be released:
__Visit Notes __Visit Summary __Immunization Record __Medications __Labs __EKGs
__Chart Cover __School/Work Excuse __Other: _____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. This authorization will terminate on the following date, event or condition: _____. If no date, event or condition specified, this authorization will expire in ***one year*** from the signature date. I also understand my refusal to sign this authorization will not affect my ability to obtain treatment, payment for services or eligibility for benefits. If a service is requested by a party other than the patient for the purpose of creating health information, refusal to sign this authorization may result in the service request being denied.

I understand I can cancel this authorization and to do so I must send a written request to Sterling Health as authorized above.

I understand I can obtain a copy of my health care data and to do so I must submit a written request to Sterling Health as authorized above.

I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law, ***except for drug and alcohol treatment information.***

Printed Name: _____ Relationship to Patient: _____

Patient/Parent/Guardian/Legal Representative Signature: _____ Date: _____

Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released:

Please check the appropriate item(s):
__Psychotherapy Notes __Psychosocial Assessment __Treatment Plan __Medications
__Group Therapy Notes __Medication Management Notes __Psychiatric Eval/Tests __Psychosocial Eval/Tests
__Discharge Summary __Labs __Other (Please Specify): _____

__Alcohol/Drug Treatment Records __Alcohol/Drug Assessments __Labs & Treatment Record

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I understand that special permission must be given for the release of Mental Health/Drug and Alcohol/HIV results. I understand that by entering my signature below I am releasing the detailed information to the above listed person(s) or facility.

***** I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law. *****

Printed Name:_____ Relationship to Patient:_____

Patient/Parent/Guardian/Legal Representative Signature: _____ Date:_____

FOR FACILITY PERSONNEL ONLY

___Patient Identification Verified. Signature:_____ Date:_____