Providence Medical Group | Saint John Medical Group

Patient Demographics Update

PATIENT INFORMATION

Name of Patient (Last, First, Middle):	Date of Birth:	Age:

Home Street Address:	City:	State:	Zip:

Cell Phone Number:	Land Line Number:	e-mail:

Gender Identity:
☐Male
☐Female
☐Female-to Male
☐Male to Female
☐Genderqueer
☐Other

Marital Status:
☐Divorced
☐Legally Separated
☐Married
☐Partner
☐Single
☐Unknown
☐Widowed

Race:
☐African American
☐American Indian
☐Asian
☐I Don't Want to Say
☐Native Hawaiian/Pacific Islander
☐Other Race
☐White

Ethnicity:
☐Hispanic or Latino
☐Not Hispanic or Latino
☐I Don't Want to Say

Language:
☐English
☐Spanish
☐Other _____
☐I Need an Interpreter

Social Security Number:	Employer Status		Employer Name and Phone Number:
	☐Employed	☐Student	
	☐Not Employed	☐Retired	

Emergency Contact Name, Phone Number, and Relation:	Pharmacy of Choice and Location:
Name and Location of your Primary Care Provider:	**Name and Location of Referring Provider:**

PAYMENT INFORMATION

Person Responsible for Charges:	Primary Insurance:	Secondary Insurance:
Name:	Company Name:	Company Name:
Relationship to Patient:	ID Number:	ID Number:
Address:	Group ID Number:	Group ID Number:
Date of Birth: Social Security #:	Policy Holder Name:	Policy Holder Name:
Primary Phone Number:	Relationship to Patient:	Relationship to Patient:

Insurance Authorization & Assignment/Consent to Treatment: I hereby authorize Providence Medical Group to furnish information to insurance carriers concerning my dependents illness or myself and treatments and I hereby assign to the physician (s) all payments for medical services to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. (Must be signed regardless of insurance coverage)

➔ **Signature:** **Date:**

Lifetime Consent - Medicare Patients Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Providence Medical Group for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

➔ **Signature:** **Date:**

Providence Medical Group | Saint John Medical Group

Receipt of Notice of Privacy Practices
Medical Information Authorization

Name:	Date of Birth:	Today's Date:

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and/or request a copy of the Providence Medical Group Notice of Privacy Practice on the date indicated. If you have any questions regarding the information in the Providence Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Medical Group's Patient Privacy Officer as indicated on your Notice.

➔Patient Signature _____ Date _____

+The above authorization is required by Federal Law under HIPAA regulations.

Medical Information Authorization

☐ ***I DO NOT** authorize Providence Medical Group to leave a **voicemail message** on my phone which I provided to you in my demographic information.

☐ ***I DO** authorize Providence Medical Group to leave a **voicemail message** on my phone which I provided to you in my demographic information.

_____

☐ ***I DO NOT** authorize the physician or anyone associated with Providence Medical Group to discuss my **medical condition, treatment or test results** with anyone other than myself.

☐ ***I DO** authorize the physician or anyone associated with Providence Medical Group to discuss my **medical condition, treatment and test results** with the following people (family/friends, not to include physicians):

_____
Name Phone Relationship

_____
Name Phone Relationship

_____
Name Phone Relationship

➔ _____
Signature of patient or legal representative Date

_____
Printed name of patient/legal representative Relationship

Rev7/2015

Providence Medical Group | Saint John Medical Group

Financial Consent

Name:	Date of Birth:	Today's Date:

Financial Policy & Benefit Assignment

We are committed to providing you with the best healthcare. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility to pay.

- All new patients must complete our Patient Information form before seeing their provider, and at the beginning of every new year.
- You will also need to make updates to your demographic information if your address, phone number, insurance, or family status has changed throughout the year. These updates are the patient's responsibility.
- Failure to update your demographic and/or insurance information can lead to denied claims. Denied claims become the patient's responsibility.

Insurances

Insurance is a contract between you and your insurance company. Your insurance company will list the required co-pay for each visit on your card. Depending on your plan, your card might also list a Primary Care Physician (PCP) and that referrals are needed for any services outside your primary care office. Please check before visiting specialists' offices. For most plans, seeing a specialist without a referral will result in non-payment of the visit. We will be glad to bill any secondary insurance on your behalf, but if payment is not received within 60 days, it will become patient responsibility.

Co-Payments

Co-payments are due at the time of service and are a requirement of your insurance company. Failure to bring your required co-pay may result in your appointment being rescheduled.

Self-Pay

Patients without health insurance can qualify for a "Prompt Pay Discount" by paying 50% of the charge on the date of service. The other remaining 50% will be eliminated. Notice will be sent to the billing office of this discount. Prompt pay discounts apply only to the office visit charge and do not include labs, in house testing or injections. Specimens that require being sent out to a lab, will be billed directly to you by the lab company. For pricing on specific tests, please call the lab of your choice and specify at time of collection what lab you want your specimen sent to.

No Show and Continual Cancellations

Continual no shows and cancellations may result in you being asked to discontinue care at our practice.

→ Patient Signature: _____ Date: _____

Providence Medical Group | Saint John Medical Group

Notice of Privacy Practices

Name:	Date of Birth:	Today's Date:

Your Rights Regarding Electronic Health Information Technology

Providence Medical Group participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.orq or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.orq for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

➔ Patient Signature: _____ Date: _____

PRECISION
Foot & Ankle Specialists

8919 Parallel Pkwy, Suite 555, Kansas City, KS 66112
3550 S. 4th St, Suite 115, Leavenworth, KS 66048
P: 913-596-3940
F: 913-596-3730

New Patient Medical Intake Form

Welcome to our office

Name:
DOB:

Past medical history:

- ❑ Atrial fibrillation
- ❑ Anemia
- ❑ Arthritis, gout
- ❑ Arthritis, rheumatoid
- ❑ AIDS/HIV
- ❑ Autoimmune disorder [*type*]_____
- ❑ Bleeding disorder
- ❑ Cancer
- ❑ Circulation disease
- ❑ Congestive heart failure
- ❑ Deep venous thrombosis/blood clot
- ❑ Diabetes [*A1c/date*]_____
- ❑ Fibromyalgia
- ❑ Hypercholesterolemia
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Myocardial infarction
- ❑ Neuropathy
- ❑ Osteoporosis/osteopenia
- ❑ Raynaud's syndrome
- ❑ Stomach ulcer
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Others

_____

- ❑ Are you currently pregnant?_____
- ❑ Are you currently nursing?_____

Current Medicine [*Names and doses*]:

_____
_____
_____
_____
_____
_____
_____
_____

Allergy [*Names and reactions*]:

_____
_____
_____
_____

Surgical history [*Procedures/complications*]:

_____
_____
_____
_____

Social history:

Tobacco use: Yes/No How much [per day/week/etc]:_____

Alcohol use: Yes/No How much [per day/week/etc]:_____

PRECISION
Foot & Ankle Specialists

New Patient Medical Intake Form

Welcome to our office

8919 Parallel Pkwy, Suite 555, Kansas City, KS 66112
3550 S. 4th St, Suite 115, Leavenworth, KS 66048
P: 913-596-3940
F: 913-596-3730

Name:
DOB:

Family history:

Relationship	Diabetes	Foot deformity	Neuromuscular disease	Cancer

Chief complaint:

What brings you to the office? _____

When did the symptom start? _____

What relives the symptoms? _____

What exacerbates the symptoms? _____

What treatments have you tried? _____

What sports/activities are you involved in? _____