TODAY'S DATE / /	PATIENT INFORMATION /CONSENT TO TREAT /HIPPA FORM FLINT HILLS FAMILY MEDICINE

PATIENT INFORMATION — PLEASE PRINT

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)			
ADDRESS:	CITY:	STATE:	ZIP:
SOCIAL SECURITY NUMBER:	Provider (please circle) Dr. Schmid Dr. Ruxton	Please circle (child, employed, student Military)	HOME PHONE NUMBER / CELL PHONE #:
DATE OF BIRTH:	E-MAIL ADDRESS:	MARITAL STATUS:	
I authorize to have Lab data sent by e-mail (please circle one):	YES	NO	
EMPLOYER NAME:	BUSINESS PHONE: EXTENSION:	OCCUPATION:	
EMPLOYER STREET ADDRESS:	CITY:	STATE:	ZIP:

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)				RELATIONSHIP: spouse, parent, etc.
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	BUSINESS PHONE:		EXT.
EMPLOYER NAME:	STREET ADDRESS:	CITY:	STATE:	ZIP:

CONCERNING INSURANCE

PRIMARY INSURANCE COMPANY NAME	GROUP #	ID/CERTIFICATE #
SUBSCRIBER NAME		
SECONDARY INSURANCE COMPANY NAME	GROUP #	ID/CERTIFICATE #
SUBSCRIBER NAME		
OTHER INSURANCE INFORMATION		

EMERGENCY AND OTHER INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY			RELATIONSHIP
ADDRESS (NUMBER) (STREET)			(APT #)
CITY	STATE	ZIP	HOME PHONE
OTHER DOCTORS YOU SEE			
HOW DID YOU HEAR ABOUT US?			

INFORMATION

Insurance will be billed for all HMO's and PPO's with which we are contracted.
We accept assignment for Medicare; however, the patient is responsible for the copayment which Medicare calculates.
PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICES EVEN THOUGH YOU MAY HAVE INSURANCE COVERAGE—this means that should the insurer fail to pay any sums due, you are responsible for their payment.