| TODAY'S DATE / / | PATIENT INFORMATION /CONSENT TO TREAT /HIPPA FORM<br>FLINT HILLS FAMILY MEDICINE |
|---|---|

## PATIENT INFORMATION — PLEASE PRINT

| FULL LEGAL NAME (FIRST) (MIDDLE) (LAST) | | | |
|---|---|---|---|
| ADDRESS: | CITY: | STATE: | ZIP: |
| SOCIAL SECURITY NUMBER: | Provider ( please circle)<br>Dr. Schmid<br>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.

## HIPPA PRIVACY NOTICE FOR FLINT HILLS FAMILY MEDICINE

**PATIENT NAME_____**
**NOTE: PLEASE PRINT**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

1. **Uses and Disclosures:** Flint Hills Family Medicine is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of the medical office. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. Flint Hills Family Medicine may also use personal health information to carry out the medical offices day to day operations such as scheduling, quality review and appointment reminders. A list of other examples of disclosures can be obtained from the Privacy Officer upon request
2. **Required Authorizations:** Flint Hills Family Medicine will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.
3. **Privacy Compliance:** In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Flint Hills Family Medicine has adopted privacy policies regarding usage of patients' personal health information. Flint Hills Family Medicine is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.
4. **Additional Information:** For additional information regarding Flint Hills Family Medicine privacy policy or for a copy of this notice, please contact our Privacy Officer. Flint Hills Family Medicine reserves the right to change this Notice and to make the revised and changed notice effective for medical information that the medical office already has about you, as well as any information the medical office receives in the future. We will post a copy of the current notice at Flint Hills Family Medicine. The notice will contain the effective date that you filled out the registration form.

**The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.**

**The following signature acknowledges that I have received a copy of this Notice.**

**_____ Date_____/____/_____**
**Signature**

# PATIENT RESPONSIBILITY FORM/FLINT HILLS FAMILY MEDICINE

Patient Name: _____
Please print

## υ PAYMENT OF SERVICES

*I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier.*

_____ _____
**PATIENT SIGNATURE (OR PARENT FOR MINOR)** **DATE**

## υ INSURANCE BENEFITS AND INFORMATION RELEASE FORM

*I hereby authorize the Doctor to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the Doctor for any services rendered that are not paid for directly by me.*

_____ _____
**PATIENT SIGNATURE** **DATE**

## υ MEDICARE AUTHORIZATION

*I request that payment of authorized Medicare benefits be made either to me or on my behalf to physician/provider for any services furnished me by that physician/provider.*

*I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.*

_____ _____
**PATIENT SIGNATURE** **DATE**

## υ AUTHORIZATION TO TREAT MINOR

*As the parent/guardian of the above named child/minor, I hereby give permission to the Doctor above to treat the child/minor in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to the Doctor for charges for medical services rendered.*

_____ _____
**PARENT/GUARDIAN SIGNATURE** **DATE**

## υ AUTHORIZATION TO TREAT PATIENT

*I hereby give permission to the doctors of Flint Hills Family Medicine to treat the listed. My consent for any procedures in the office is implied. I will ask prior to any procedures for clarification of anything I do not understand regarding the procedures and or treatment plan. I understand that many problems that come into a primary care office are in a undifferentiated state and may take some time to sort themselves out. I also give consent for any lab tests drawn and/or xrays taken. I will notify the xray technologist is there is any chance I may be pregnant.*

_____
**PATIENT SIGNATURE** **DATE**