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

PATIENT INFORMATION — PLEASE PRINT

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)			(NICKNAME/AKA)
ADDRESS:	CITY:	STATE:	ZIP:
SOCIAL SECURITY NUMBER:	Provider: □ Dr. Schmid		Gender □ Male □ Female
DATE OF BIRTH:	E-MAIL ADDRESS:		Permission to have info (ex. Lab results) emailed? □ Yes □ No
Home Phone:	Other Phone: □ Cell □ Pager □ Fax	Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino	
Marital Status □ Married □ Single □ Divorced □ Life Partner □ Separated □ Widowed □ Other			Language (Other than English)
Race □ White □ Black/African American □ American Indian/Alaskan Native □ Asian □ Other Pacific Islander □Other			
EMPLOYER NAME:		Employer Phone:	

PHYSCIAN REFERRAL INFORMATION

Primary Care Physician:	Referring Physician:

RESPONSIBLE PARTY (INSURANCE) INFORMATION

Subscriber name:			
SS#		DOB:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)				RELATIONSHIP: □ Spouse □ Parent □ Other
ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP	HOME PHONE
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	WORK PHONE:		OTHER PHONE: □ Cell □ Pager □ Fax
EMPLOYER NAME:	STREET ADDRESS:	CITY:	STATE:	ZIP:

EMERGENCY AND OTHER INFORMATION

PERSON TO NOTIFY IN CASE OF EMERGENCY			RELATIONSHIP TO PATIENT
ADDRESS (NUMBER) (STREET)			(APT #)
CITY	STATE	ZIP	HOME PHONE
Home Phone:	Other Phone: □ Cell □ Pager □ Fax		Work Phone:
PHARMACY:			

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.

FLINT HILLS
FAMILY MEDICINE

HIPAA PRIVACY NOTICE FOR FLINT HILLS FAMILY MEDICINE

PATIENT NAME_____

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.
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. People listed as my emergency contacts may have my medical information.
5. I will authorize electronic exchange of information by opting in or out for the purpose of medical business for my behalf.
6. **Additional Information:** We will keep a copy of the current notice at Flint Hills Family Medicine. The notice will contain the effective date that you filled out this 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 read and understand 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**