Kansas City Bone & Joint Clinic, P.A. Account# _____
Division of Signature Medical Group of KC, PA (Office Use Only)

Patient Name: (Please Print) _____Date of Birth:_____

I consent to allow automated appointment reminder calls to the following numbers.

☐ Cellular Phone_____ _____ ☐ NO
Number ***Initials***

☐ Home Phone_____ _____ ☐ NO
Number ***Initials***

I consent to being contacted regarding my interest in any clinical research studies ☐ YES ☐ NO

Authorization to release Information: I hereby authorize this facility to release my Protected Health Information to: Check all that apply:

☐ None: _____

☐ Parents: _____ Phone: _____

☐ Spouse: _____ Phone: _____

☐ Children: _____ Phone: _____

☐ Children: _____ Phone: _____

☐ Personal Representative: _____Phone: _____

☐ Guardian: _____ Phone: _____

☐ Others: _____ Phone: _____

☐ Employer/FMLA _____ Phone: _____

☐ Disability insurance _____ Phone: _____

Sign Here ➔ Patient Signature: _____Date _____

Please check out our interactive website *WWW.KCBJ.COM*
Revised 9/14