A DIVISION OF SIGNATURE MEDICAL GROUP OF K.C., PA

Patient Name: ______________________________________ **Date of Birth:**___________________

Communications:

Please provide all patient contacts that may be used for communications from Signature Medical Group.

Check the box that indicates your primary method to be contacted.

[ ] Home: ____

[ ] Work: ____

[ ] Cell: ____

[ ] E-mail: ____

HIPAA:

CONSENT: I hereby give my consent to any physician member of Kansas City Bone & Joint Clinic, a Division of Signature Medical Group of KC, PA or their designee to provide medical treatment to me, or to my minor child ________________________, encompassing diagnostic and therapeutic procedures. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations at this clinic.

RESPONSIBILITY FOR PAYMENT: I hereby acknowledge that any portion of the charge for services rendered or supplies provided by the physicians of Kansas City Bone & Joint Clinic, a Division of Signature Medical Group of KC, PA has not paid by my designated insurance carrier, Medicare, or guarantor agency will be my responsibility to pay in full. I understand that I am responsible for furnishing valid referrals from my primary care physician when required. I understand that if I elect to visit a specialist physician and receive specialty services without a valid written referral when one is required by my insurance, then I am solely responsible for payment of services when rendered and/or supplies when provided.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT: I acknowledge that a copy of Signature Medical Group of KC, PA's Notice of Privacy Practices has been made available to me.

AUTHORIZATION & ASSIGNMENT: Insurance - I hereby authorize Kansas City Bone & Joint Clinic, a Division of Signature Medical Group of KC, PA and its Physicians to furnish to or receive from insurance companies and other health care provider, any and all information concerning my medical or physical condition, diagnosis and/or treatment. I hereby assign payment of medical/surgical benefits to the Kansas City Bone & Joint Clinic, a Division of Signature Medical Group of KC, PA for medical services rendered, or supplies provided, to myself or my dependents.

MEDICARE - I request that payment of authorized Medicare benefits otherwise payable to me, be made on my behalf to Kansas City Bone & Joint Clinic, a Division of Signature Medical Group of KC, PA, for any services or supplies furnished to me by that physician. I authorize the Kansas City Bone & Joint Clinic, a Division of Signature Medical Group of KC, PA physicians and authorized personnel to release to the Centers for Medicare and Medicaid Services and its agents, any medical information needed to determine benefits payable for related services or supplies.

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MEDICARE SECONDARY PAYER QUESTIONNAIRE:

(MEDICARE PATIENTS ONLY) OMB No. 0938-0214

1. Is the patient a Veteran? ( ) Yes ( ) No

   a. Did the VA refer you here for treatment? ( ) Yes ( ) No

   b. Does the patient have a VA "fee basis ID card? ( ) Yes ( ) No

2. Do you have a federal Black Lung card? ( ) Yes ( ) No

3. Is this medical condition due to an accident of any kind? ( ) Yes ( ) No

   a. If yes, was it: ( ) Work Related ( ) Motor Vehicle ( ) Injured in own home ( ) Other

4. Is the patient covered by an employer's health insurance plan through their own employment or that of a family member? (not retiree coverage) ( ) Yes ( ) No

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PHI Consent and Release of Information:

* I consent to Kansas City Bone and Joint Clinic, to obtain my prescription and medication records. [ ] YES [ ] NO

* I consent to allow automated appointment reminders and telephone calls to the following numbers (check all that apply):

[ ] Cell; regarding the following: [ ] appointments [ ] billing [ ] none.

[ ] Home; regarding the following: [ ] appointments [ ] billing [ ] none.

*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 or billing/financial information to the following:

Name: ________________________________Relationship: ______________________Phone:____________________

[ ] All [ ] PHI [ ] Financial

Name: ________________________________Relationship: ______________________ Phone:____________________

[ ] All [ ] PHI [ ] Financial

[ ] I do not authorize this facility to release my Protected Health Information or billing/financial information

____ ________________________

Patient Signature or Guardian if Patient is Under 18 Years Old Date

MAIN OFFICE
CORPORATE MEDICAL PLAZA, BUILDING #1
10701 NALL AVE., SUITE 200 OVERLAND PARK, KS 66211

PHONE: (913) 381-5225 FAX: (913) 901-0186

WWW.KCBJ.COM

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