Mid-Kansas Women's Center, PA

Patient Information Sheet

Last Name ______ First Name ______ MI ______ Preferred or Nickname ______ Maiden Name ______

Date of Birth ______ SSN ______ Primary Language ______

Address ______ City ______ KS State Zip ______

**** EMAIL ****

Phone (please check the box next to the best number to reach you):

Home ______ ☐ Work ______ ☐ Cell ______ ☐

FEDERAL LAW requires that we collect the following demographic information from all patients. If you would prefer not to answer, please check the "Decline" box.

Race: ______ Decline ☐ **Do you consider yourself to be of Hispanic/Latino descent? (Circle one)** **Yes** **No** Decline ☐

Emergency Contact

By listing the individual named below as an emergency contact, you are authorizing Mid-Kansas Women's Center to release information regarding the nature of your emergency and your location.

Name: ______ **Relationship:** ______

Home Phone: ______ **Work:** ______ **Cell:** ______

Insurance

Primary Ins: ______ **Policy ID#:** ______

Policy Holder: ______ **DOB:** ______ **Group#:** ______

Secondary Ins: ______ **Policy ID#:** ______

Policy Holder: ______ **DOB:** ______ **Group#:** ______

Responsible Party

Complete this section if you would like billing information to be sent to someone OTHER THAN THE PATIENT OR POLICYHOLDER.

Full Name: ______ **Relationship:** ______

Social Security#: ______ **Date of Birth:** ______

Address: ______ **City, St, Zip:** ______

Home Phone: ______ **Work:** ______ **Cell:** ______

Referral Info

Primary Care Physician: ______ **Phone:** ______

Address: ______ **City, St, Zip:** ______

Who referred you to our office? ______

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Pharmacy

Preferred Pharmacy: ______________________ **Address:** ______________________

Do you use Custom Rx East? ☐ **Or** **Custom Rx West?** ☐

E-PRESCRIBE AND PHARMACY BENEFITS MANAGEMENT (PBM)

ePrescribing allows physicians to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Benefits are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs who provide medication history and maintain formularies, or lists of drugs covered by a particular drug benefit plan.Having this information allows your provider to help you find the most beneficial and cost-effective treatments while improving your overall care.

By signing this consent form you are agreeing that Mid-Kansas Women's Health can request and use your prescription medication history from other health care providers and/or third party benefit payors for treatment purposes.

Signature: ______________________ **Date:** ______________________

RELEASE OF INFORMATION

May we give out any medical/ financial information to anyone other than yourself, your treating physician, or insurance company?

Yes ________ **No**________ **If yes, to whom:**

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

Name: ______________________ **Relationship:** ______________________

PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of this clinic's Notice of Privacy Practices.

Patient Name (Print): ______________________ **Date:** ______________________

Signature of Patient/ Legal Guardian: ______________________ **Relationship:** ______________________

I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If item 12 of CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above in Medicare/ Other Insurance Company assigned cases. Co-pay must be paid at time of service. Please let us know if you need more information.

Patient Name (Print): ______________________ **Date:** ______________________

Signature of Patient/ Legal Guardian: ______________________ **Relationship:** ______________________