Kansas Medical Clinic

Patient Information

In order to serve you properly we need the following information. All information is strictly confidential

Patient Name (Last, First, MI)	Birth Sex ☐Male ☐Female	Birthdate: (MM/DD/YY)	Marita; Status ☐ Single ☐Divorce ☐ Married ☐ Widowed

Sexual Orientation: ☐ Lesbian, gay, homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Do not know
☐ Choose not to disclose. ☐ Other _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Female-to-Male transgender ☐ Male-to-Female transgender
☐Genderqueer ☐ Choose not to disclose. ☐Other _____

Address	City	State	Zip

Email Address	Home Phone	Cell Phone

Employer	Social Security Number

Employment Status ☐ Full Time ☐ Part Time ☐Unemployed ☐ Self	Student Status ☐Full Time ☐Part Time	Responsible Party ☐Self (If not self, provide name, DOB & Relationship) Name/DOB	Relationship

Emergency Contact Name and Relationship	Preferred Phone: Alternate Phone:

Insurance Subscriber Name	Subscribe DOB (MM/DD/YY)	Subscriber SSN	☐ Spouse ☐Parent ☐Guardian ☐Other
Secondary Insurance Subscriber Name	Subscribe DOB (MM/DD/YY)	Subscriber SSN	☐ Spouse ☐Parent ☐Guardian ☐Other

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African Am. ☐Pacific Islander ☐Hispanic ☐White ☐Prefer not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to answer

Preferred Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian Other (Specify)_____

How did you hear about us?

Preferred Pharmacy:

Primary Care Provider:	Referring Physician:
Do you have an advanced directive	☐ DNR ☐ YES ☐ NO

Authorization to release information and assignment of Insurance Benefits. I acknowledge that all the information I have provided to Kansas Medical Clinic (KMC) is accurate and correct. I request payment of authorized Medicare/Insurance benefits to me, or on my behalf, for any services furnished to me by KMC including physician services. I authorize any holder of medical and other information about me to release to Medicare/Insurance and its agents any information needed to determine these benefits for related services. I understand that I am responsible for any and all balances owed regardless of insurance.

Patient's Signature: _____ Date_____

Signed by : _____

Relationship:_____ Relationship:_____

Rev: 4/24

PATIENT MEDICATION RECONCILIATION Form

Endoscopy Center of Topeka

Name:	Date of Birth:	Age:
Allergies: ☐ Yes ☐ No known allergies	Latex Allergy ☐ No ☐ Yes ☐ Testing performed for Latex allergy	

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Signature of person filling out form_____Date:_____

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	How Often	Continue After Discharge	Stop After Discharge

Signature of Patient/Responsible Person:_____Date:_____

Nurse Signature:_____Date:_____

Physician Signature:_____Date:_____

CRNA Signature:_____Date:_____

Dr. Challa &

KMC

KANSAS MEDICAL CLINIC PA

You have my permission to contact me:

_____ On my home answering machine:_____
Phone Number

_____ At my workplace:_____
Phone Number

_____ On my workplace voicemail:_____
Phone Number

_____ On my cell phone:_____
Phone Number

_____ On my cell phone voicemail:_____
Phone Number

_____ At the following number:_____
Phone Number

With whom may we discuss your medical information?

Spouse:_____
Phone Number

Children:_____
Phone Number(s)

Siblings:_____
Phone Number(s)

Parents:_____
Phone Numbers(s)

Friends:_____
Phone Number(s)

_____

Patient's Signature Date of Birth

_____

Patient's Name Printed
Today's Date

Dr. Challa &
KMC
KANSAS MEDICAL CLINIC PA
GASTROENTEROLOGY
ENDOSCOPY CENTER OF TOPEKA

2200 SW 6TH Avenue, Suite 103 I Topeka, KS 66606-1707

ADVANCED NOTICE TO PATIENTS

Please read, initial where indicated and sign below

Kansas Medical Clinic and Endoscopy & Surgery center of Topeka are now offering anesthesia services to their patients. Propofol is an IV drug administered by a Certified Registered Nurse Anesthetist (CRNA), who is trained to administer your sedation. Please note that charges for your anesthesia services (CRNA) are separate from and in addition to routine charges for endoscopic services rendered by your physician, the surgery center, and pathology services (biopsies, if taken). These charges are generally covered by your health insurance policy.

_____ (**Initial here)** I understand that following my receipt of the professional services referred to above. I acknowledge that my insurance will be billed and I will be responsible for payment of any deductibles and co-insurance that may be applicable.

Non-Coverage of anesthesia for services provided

_____ (Initial here) I am aware that my insurance company may not pay/cover this service, and I acknowledge that I will be billed the following amount if my insurance company denies payment for any reason: $200.00

_____ _____

Patient Signature Date

_____

Print Name

KANSAS MEDICAL CLINIC, P.A.

Thank you for choosing Kansas Medical Clinic as your health care provider. Your healthcare is a partnership between you and your provider and in that regard, we are committed to providing you with quality and affordable healthcare. As the patient, you also share in your personal healthcare and the following is a statement of our office and financial policies to assist you. Please read and sign prior to treatment.

Office Policy

1. Office Hours. Our office hours are Monday-Friday from 8:00am to 5:00pm. We close the office daily for lunch from 12:00-1:00pm. We also close in observance of the following holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Friday after Thanksgiving, and Christmas. After Hours, if you experience a life-threatening emergency call 911 or go to your nearest emergency room. If you have a non-emergency call, you may leave a message on the voice mail and your call will be returned on the next business day.
2. Appointment Times. Our policy is to call patients two days prior to their appointment to remind them of the date and time. We perform these calls as a courtesy to our patients. Arriving promptly for your appointment is not only a courtesy, but a consideration for those patients whose appointments are scheduled after yours. Recognizing that everyone's time is valuable, and that appointment time is limited, we ask that you provide 24-hour notice if you are unable to keep your appointment.
3. No-Show or Cancellation less than 24 hours in advance: We want to ensure patients are able to attend their scheduled visits and send out both phone call and text message reminders. We ask that you provide 24 hours' notice if you are unable to attend your scheduled visit, which allows us to offer the appointment to another patient. Effective June 1, 2025, KMC will be implementing a fee for missed appointments or late cancellations. To avoid this fee, please ensure that you cancel or reschedule your appointment at least 24 hours in advance. If a cancellation or no-show pattern is identified, which is determined as missing three appointments without adequate prior notice our physicians/providers do retain the right to terminate you from the practice at their discretion.
4. Phone calls. In order for us to see patients at their scheduled appointment time, it may not be possible to answer your phone calls immediately. In that regard, you may be asked to leave a voice mail message for our staff. We will attempt to return calls received before 3:30 the same day; calls received after 3:30 may be returned the following business day.

Financial Policy

1. Payment for Services. Please understand that payment for healthcare services is required and is your obligation as a result of receiving services from Kansas Medical Clinic and its subsidiaries. We accept cash, checks, Visa, and Mastercard.
2. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is due at each visit. Please let the staff know if you need to visit with a manager to arrange a payment plan. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. If your insurance requires a referral or for services to be done by a specific laboratory, it is your responsibility to obtain the referral or let us know where your lab specimens should be sent. Please contact your insurance company with any questions you may have regarding your coverage.
3. Copayments and deductibles. All co-payments and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company.

4. Non-covered Services. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
5. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information you may be responsible for the balance of a claim. Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
6. Claims Submission. We utilize a billing company to submit your claims and assist you in any reasonable manner to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company has not paid for claims submitted after 90 days, the balance may become your responsibility to pay. You need to contact your insurance regarding payment if they have not paid and you have a dispute with them regarding payment. Your insurance benefit is a contract between you and your insurance company.
7. Pathology lab specimen: We utilize Kansas Medical Clinic Pathology Lab to process our specimens. Dermatology specimens are read by a Board-Certified Pathologist. Please advise your provider if you wish for your lab specimen to be sent to any other lab.
8. Minors. For children under the age of 18, an adult is responsible for payment. In addition, in many instances minors cannot receive medical treatment without the consent of a parent or legal guardian.
9. Nonpayment. After your insurance has paid or denied your claim you will receive a statement. If you are unable to pay your bill in full you will need to contact the Customer service number on the bill to set up payment arrangements. Consideration of the inability to pay is made on the basis of submitted financial documentation and can be obtained by contacting the number on your bill or our office and requesting a Hardship Form. Please be aware if your balance remains unpaid and overdue we may refer your account to a collection agency.

Our practice is committed to providing the best treatment for our patients. Thank you for understanding our office and financial policies. Please let us know if you have any questions or concerns.

By Signing below, I hereby certify that I have read and understand the office and financial policies and agree to abide by their guidelines and that I authorize Kansas Medical Clinic or their agents to release the necessary information in order to complete and process my insurance claims.

_____ _____

Signature of patient or responsible party Date

_____ _____

Printed name of patient or responsible party Relationship to patient

ENDOSCOPY CENTER OF TOPEKA

Patient Belongings and Valuables

Patients and visitors are responsible for all belongings. The Endoscopy Center of Topeka is not responsible for replacing lost or misplaced items. We recommend you bring only essential items to the Center and offer the following tips to help keep your personal items secure:

Valuables

Please leave all valuables at home or leave them with your designated driver that accompanies you to your appointment; this includes cash, checkbooks, credit cards, jewelry and other items deemed to be of value, wallet, purse, cell phone, laptop computers, e-readers, iPads, etc., or any other item that would be considered a loss if misplaced. Patients move about during their admission for procedures. If family members/driver are not present, valuable items should be kept in the belongings bag that is provided to the patient. The personal belongings bag is kept at the bedside for the entirety of the admission.

Lost Items

The Endoscopy Center of Topeka does not replace lost items. We will be happy to check our lost and found for your items.

Denture Care

A staff member will provide a denture cup to store them in when not in use. The cup will be labeled with the patient's name.

Hearing Aids/Eyeglasses

Hearing aids should be kept in the original case provided upon purchase. If the original case is not available, nursing staff will provide a container labeled with patient name to store the hearing aids in when not in use. Staff will place eyeglasses in a safe resting place below patient's bed during procedure.

ENDOSCOPY CENTER
OF TOPEKA

Do you have everything you need before leaving for your appointment?

- **Photo ID**
- **Insurance Card(s)**
- **Filled out paperwork that was sent to you**
- **Current list of medications**
- **Driver**
- **Remote for any implanted devices**

ENDOSCOPY CENTER OF TOPEKA

Important Notice:
Screening vs. Diagnostic Colonoscopy

We want to ensure you understand the difference between **screening** and a **diagnostic** colonoscopy, as this may affect your insurance coverage and out-of-pocket costs.

Screening Colonoscopy

- A routine exam for patients with no symptoms.
- Recommended for preventative care, typically starting at age 45 or as advised by your doctor.
- Usually covered by insurance under preventive benefits.
-

Diagnostic Colonoscopy

- Performed when a patient has symptoms such as bleeding, pain, diarrhea, or abnormal test results.
- If polyps are found and removed during a screening, some insurers may reclassify it as diagnostic.
- May be subject to deductibles, co-pays, or co-insurance under your medical benefits.
-

Billing Requirements

By law, we are required to bill your colonoscopy as **diagnostic** if you have any symptoms, even if the procedure was originally scheduled as a screening. Insurance coverage varies, so we recommend checking with your insurance provider regarding your benefits. If you have any questions, please contact your insurer before your procedure.

Dr. Challa &

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KANSAS MEDICAL CLINIC PA

Beyond the Surface

Cancellation Policy

If you cancel your appointment less than 48 hours before the scheduled time, a cancellation fee of $100 will be charged. Thank you for being valued patient and for your understanding and cooperation as we institute this policy.

If the patient has Advance Directives which have been provided to the surgery center that impact resuscitative measures being taken, we will discuss the treatment plan with the patient and his/her physician to determine the appropriate course of action to be taken regarding the patient's care.

Complaints/Grievances: If you have a problem or complaint, please speak to one of our staff to address your concern. If necessary, your problem will be advanced to center management for resolution. You have the right to have your verbal or written grievances investigated and to receive written notification of actions taken.

The following are the names and/or agencies you may contact:

Ashley Michaelis R.N., Center Director
Endoscopy Center of Topeka
2200 SW 6th Avenue, Suite 103
Topeka, KS 66606-1707
Phone: 785.354.1254

You may contact the state to report a complaint.

Kansas Department of
Health and Environment
1000 SW Jackson
Topeka, KS 66612
Phone: 785.296.1500
Complaint Hotline: 1.800.842.0078
State Website: www.kdheks.gov

Medicare beneficiaries may also file a complaint with the Medicare Beneficiary Ombudsman.
Medicare Ombudsman Website:

www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare: www.medicare.gov
or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: oig.hhs.gov

Physician Ownership

Physician Financial Interest and Ownership:

The center is owned, in part, by the physicians. The physician(s) who referred you to this center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with federal regulations.

THE FOLLOWING PHYSICIANS HAVE A FINANCIAL INTEREST IN THE CENTER:

Shekhar Challa M.D.

Dr. Challa & KMC GASTROENTEROLOGY
Beyond the Surface

ECOT ENDOSCOPY CENTER OF TOPEKA

Endoscopy Center of Topeka
2200 SW 6th Avenue, Suite 103
Topeka, KS 66606-1707

Patient's Rights and Notification of Physician Ownership

EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL AND TO ACTIVELY PARTICIPATE IN AND MAKE INFORMED DECISIONS REGARDING HIS/HER CARE. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING PATIENT RIGHTS AND RESPONSIBILITIES, WHICH ARE COMMUNICATED TO EACH PATIENT OR THE PATIENT'S REPRESENTATIVE/ SURROGATE PRIOR TO THE PROCEDURE/SURGERY.

PATIENT'S RIGHTS:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive considerate, respectful and dignified care from competent personnel.
- To be provided privacy and security during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, or exploitation during the course of patient care.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.

(continued)

- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- To have care delivered in a safe environment, free from all forms of abuse, neglect, harassment, or reprisal.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
- To be informed of their right to change providers if other qualified providers are available.
- To know which facility rules and policies apply to his/her conduct while a patient.
- To have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's care. The patient's written consent for participation in research shall be obtained and retained in his/her patient record.
- To examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.
- To be advised if the physician providing care has a financial interest in the surgery center.
- Regarding care of the pediatric patient, to be provided supportive and nurturing care which meets the emotional and physiological needs of the child and to support participation of the caregiver in decisions affecting medical treatment.

PATIENT'S RESPONSIBILITIES:

- To provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- To follow the treatment plan prescribed by their provider, including pre-operative and discharge instructions.
- To provide a responsible adult to transport them home from the facility and remain with them for 24 hours, if required by their provider.
- To inform their provider about any living will, medical power of attorney, or other advance healthcare directive in effect.
- To accept personal financial responsibility for any charges not covered by their insurance.
- To be respectful of all the healthcare professionals and staff, as well as other patients.

If you need an interpreter:
If you will need an interpreter, **please let us know** and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please make arrangements to have them accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:
- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice a grievance regarding treatment or care that is, or fails to be, furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Rights and Respect for Privacy and Safety

The patient has the right to:
- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

Statement of Nondiscrimination

Endoscopy Center of Topeka complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Endoscopy Center of Topeka cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Advance Directives

An "Advance Directive" is a general term that refers to your instructions about your medical care in the event you become unable to voice these instructions yourself. Each state regulates advance directives differently. STATE laws regarding Advanced Directives are found in Kansas Statutes Chapter 65, Article 28.101-109. In the state of Kansas, a patient has the right to make decisions about their healthcare through a written document that tells doctors and health care providers how you would want medical decisions you have made to be carried out. An Advance Directive will allow you to make decisions about your future health care if you are not able to make those decisions at the time treatment is recommended. It also tells your doctor and loved ones what treatment you want or do not want. There are two kinds of Advance Directives: living wills and durable power of attorney for health care decisions. *http://kansasstatutes.lesterama.org/Chapter_65/Article_28/#65-28.101*

You have the right to informed decision making regarding your care, including information regarding Advance Directives and this facility's policy on Advance Directives. Applicable state forms will also be provided upon request. A member of our staff will be discussing Advance Directives with the patient (and/or patient's representative or surrogate) prior to the procedure being performed.

Endoscopy Center of Topeka respects the right of patients to make informed decisions regarding their care. The Center has adopted the position that an ambulatory surgery center setting is not the most appropriate setting for end of life decisions. Therefore, it is the policy of this surgery center that in the absence of an applicable properly executed Advance Directive, if there is deterioration in the patient's condition during treatment at the surgery center, the personnel at the center will initiate resuscitative or other stabilizing measures. The patient will be transferred to an acute care hospital, where further treatment decisions will be made.

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