ACKNOWLEDGEMENT OF NOTICE

I acknowledge receipt of the Kansas Medical Clinic
Notice of Privacy Practices.

______________________________ ______________

Patient's Signature Date

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Print Patient's Name

KANSAS MEDICAL CLINIC, P.A.

Patient: ___________________________________

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 health care. 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 8:00am to 5:00pm. We close the office daily from 12:00pm-1:00pm for lunch. 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 to 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 hours notice if you are unable to keep your appointment. If a cancellation or no show pattern is identified, which is determined as missing three appointments in a row, our physicians/providers do retain the right to terminate you from the practice at their discretion.
3. **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 Dermatopathologist and endoscopy specimens by an experienced 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, minors cannot receive medical treatment without 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 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 to 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**

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)	Sex □ Male □ Female	Birthdate (MM/DD/YY)	Marital Status □ Single □ Divorced □ Married □ Widowed

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	Home Address □ Same as Patient or complete below Preferred Phone: Alternate Phone:

Insurance Subscriber Name	Patient Work Number	□ Spouse □ Parent □ Guardian □ Other

Subscriber Address	Subscriber DOB (MM/DD/YY)	Subscriber SSN

Insurance Subscriber Name #2	□ Spouse □ Parent □ Guardian □ Other

Subscriber Address	Subscriber DOB (MM/DD/YY)	Subscriber SSN

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:

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: ________________

Rev: 2/15

You have my permission to contact me:

_______ On my home answering machine: ______________________
Phone Number

_______ At my workplace: ______________________
Phone Number

_______ On my workplace voice-mail: ______________________
Phone Number

_______ On my cell phone: ______________________
Phone Number

_______ At 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

Sibling/s: ______________________
Phone Number

Parent/s: ______________________
Phone Number

Friend/s: ______________________
Phone Number

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Patient's Signature　　　　Date of Birth

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Patient's Name Printed　　　　Today's Date