

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: (MM/DD/YY)	Marita; Status <input type="checkbox"/> Single <input type="checkbox"/> Divorce <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Sexual Orientation: <input type="checkbox"/> Lesbian, gay, homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Do not know <input type="checkbox"/> Choose not to disclose. <input type="checkbox"/> Other _____				
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Female-to-Male transgender <input type="checkbox"/> Male-to-Female transgender <input type="checkbox"/> Genderqueer <input type="checkbox"/> Choose not to disclose. <input type="checkbox"/> Other _____				
Address		City	State	Zip
Email Address		Home Phone	Cell Phone	
Employer			Social Security Number	
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed Self	Student Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Responsible Party <input type="checkbox"/> Self (If not self, provide name, DOB & Relationship)		
		Name/DOB	Relationship	
Emergency Contact Name and Relationship		Preferred Alternate	Phone:	Phone:
Insurance Subscriber Name		Subscribe DOB (MM/DD/YY)	Subscriber SSN	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other
Secondary Insurance Subscriber Name		Subscribe DOB (MM/DD/YY)	Subscriber SSN	<input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African Am. <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer				
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Prefer not to answer				
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Russian Other (Specify) _____				
How did you hear about us?				
Preferred Pharmacy:				
Primary Care Provider:			Referring Physician:	
Do you have an advanced directive			<input type="checkbox"/> DNR <input type="checkbox"/> YES <input type="checkbox"/> 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: _____

PATIENT MEDICATION RECONCILIATION Form

Endoscopy Center of Topeka

Name:		Date of Birth:	Age:
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No known allergies		Latex Allergy <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Testing performed for Latex allergy	
Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	How Often	<u>Continue</u> After Discharge	<u>Stop</u> After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	How Often	<u>Continue</u> After Discharge	<u>Stop</u> 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	<u>Continue</u> After Discharge	<u>Stop</u> After Discharge

Signature of Patient/Responsible Person: _____ Date: _____

Nurse Signature: _____ Date: _____

Physician Signature: _____ Date: _____

CRNA Signature: _____ Date: _____



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



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

Patient Financial Policy

Payment Method on File & Appointment Cancellation Policy

Thank you for choosing our practice. We value your trust and are committed to providing high-quality, timely care to every patient. To help us manage our appointment schedule efficiently and ensure appointment availability for all patients, we require a valid credit or debit card to be securely maintained on file.

Payment Method on File

A valid payment method is required to:

- Secure your scheduled appointment(s).
- Process any patient financial responsibility after insurance has processed your claim, when applicable.
- Assess no-show or late cancellation fees in accordance with this policy.

Your card **will not be charged** simply for being kept on file. It will only be used for authorized patient financial responsibilities as outlined below.

Appointment Cancellation Policy

We understand that unexpected situations may arise. If you need to cancel or reschedule your appointment, we ask that you notify our office **at least 48 business hours before your scheduled appointment time.**

Appointments that are canceled with **less than 48 business hours' notice**, or appointments that are missed without notifying our office, may be subject to a **no-show/late cancellation fee**. This fee may be charged to the payment method maintained on file.

Appointments canceled with **less than 48 business hours' notice**, as well as appointments missed without prior notification ("no-shows"), may result in the following fees:

- **Office Visit:** \$50.00
- **Procedure (including endoscopic procedures):** \$100.00



These fees are not covered by insurance and are the patient's responsibility. They may be charged to the payment method maintained securely on file.

Business hours include only the days and times our office is open. Weekends and recognized holidays are not considered business hours when calculating the required notice period.

Payment Processing

Whenever possible, we will notify you before processing any outstanding patient balance or applicable no-show/late cancellation fee.

Your payment information is stored through a secure, encrypted payment processing system that complies with applicable payment security standards. Our practice does not store or have access to your complete credit or debit card information.

Patient Acknowledgment

By signing below, I acknowledge that I have read and understand this Patient Financial Policy. I authorize the practice to securely maintain a valid payment method on file and understand that it may be used for authorized patient financial responsibilities, including applicable no-show or late cancellation fees resulting from appointments canceled with less than **48 business hours' notice** or missed appointments.

I understand that it is my responsibility to keep my payment information current and to notify the practice if my payment method changes or expires.

Patient Name: _____

Signature: _____

Date: _____

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



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.



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.



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.