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	Last Dose Taken/Time	How Often	Continue After Discharge	Stop After Discharge

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Medication (print please)	Dose	Last Dose Taken/Time	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

Signature of Patient/Responsible Person: _____ Date:_____

Nurse Signature:_____ Date:_____

Physician Signature:_____ Date:_____

ENDOSCOPY CENTER
OF TOPEKA

Patient Demographic Form

Please fill out entire form and sign so we can bill your insurance company.

Account Number: _____ Primary/Referring Physician _____

Patient's Name: _____

Last Name First Name Middle Initial

SS#: ___-___-___ Date of Birth: ___/___/___ Sex: [M / F]

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Patient Employer: _____ E-mail address _____

If you have more than one insurance company, please present both cards so that we may file with each in order to obtain maximum benefit on your behalf.

Primary Insurance	**Secondary Insurance**
Insurance: _____	Insurance: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Insured's Name: _____	Insured's Name: _____
Relation to Patient: _____	Relation to Patient: _____
Insured Date of Birth _____	Insured Date of Birth _____

****If your insurance requires you to use a specific lab please list:** _____

Financial Policy

The total cost for medical services is made up of several fees. The Endoscopy Center's fee and the physician's fee are the two fees always charged. It is possible to have a pathologist's fee. Each fee is billed separately by the provider of the service.

- THE ENDOSCOPY CENTER'S BILL IS SEPARATE FROM THE PHYSICIAN'S
- Endoscopy Center of Topeka's fee covers the cost of providing the technicians, nurses, equipment, medication and supplies involved in the performance of your services. Our billing service company is Comp One; please call Comp One at 785.232.2284 for any questions pertaining to your Endoscopy Center of Topeka bill.
- The physician's professional service fee is for providing the Endoscopy procedure, supervising, interpreting and consulting with you and your referring physician. Your gastroenterologist will bill separately for his/her professional services.
- All biopsies and tissue samples taken during your procedure will be sent to a pathologist. You will be billed separately by the pathologist reviewing the tissue.

Our billing service will assist in filing your insurance, but you, the patient, are responsible for your medical bill. Authorizations and pre-certifications are the responsibility of your primary physician's office. Any financial concerns should be handled prior to your procedure.

I authorize the release of any medical or other information acquired in the course of my treatment to my insurance company. Additionally, I authorize all insurance payments to be made directly to the Endoscopy Center of Topeka for all medical care rendered. I understand that I am responsible for any and all balances owing regardless of insurance.

Patient/Responsible Adult Signature: _____ Date: _____

Reviewed Date & Initial _____ Reviewed Date & Initial _____ Reviewed Date & Initial _____

Dr. Challa &
KMC
GASTROENTEROLOGY
ENDOSCOPY CENTER OF TOPEKA
2200 SW 6th Avenue, Suite 103 | 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 charges (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

Dr. Challa & KMC GASTROENTEROLOGY

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

_____
Patient's Signature Date of Birth

_____
Patient's Name Printed Today's Date

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:

Susan Smith R.N., Center Leader
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 Web site: http://www.kdheks.gov/

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

Medicare Ombudsman Web site:
http://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: http://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:

Shekkar Challa M.D.

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

(continued)

and treatment are confidential and shall be conducted discretely.

- 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 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.
Endoscopy Center of Topeka 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人

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 basic 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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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**