Patient Information

Last Name _____ First Name _____ MI _____ SSN _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Cell Phone Carrier _____
Date of Birth _____ Gender _____ Marital Status _____ Email _____

Guarantor Information

Last name _____ First Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Patient/Guarantor's Employer

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

Emergency Contact

Last Name _____ First Name _____ Relationship _____ Phone _____
Problem Description _____ Date of Injury or Onset of Symptoms _____

Please circle one of the following- Type of accident: None Other Work Auto

If Motor Vehicle Accident list the state the accident occurred in: _____

Details of Accident: _____

Primary Insurance

Insurance _____ ID _____
Group # _____ Co-Pay _____ Co-Insurance _____

Subscriber
Name _____
Relationship _____
Date of Birth _____

Secondary Insurance

Insurance _____ ID _____
Group # _____ Co-Pay _____ Co-Insurance _____

Subscriber
Name _____
Relationship _____
Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Financial Policy.
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____ **Date:** _____

Minors under the age of 18 need to be accompanied at their first visit by a parent or guardian to sign patient information and financial responsibility forms. The parent of the guardian is responsible for full payment. If the parents are separated and both legally responsible for the child you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Signature: _____ **Date:** _____

How did you find our clinic?

Physician Referral ☐ A friend or relative referred me ☐ Internet Search ☐ Former Patient ☐ Other☐

Other Party Liability
Patient Information Form

Phone: 785-291-4013
Fax: 785-290-0771
Maildrop: 217D5
www.bcbsks.com

BlueCross BlueShield of Kansas

Section 1

Member name _____
Last First MI

Member's ID No. _____ Provider _____

Patient Name _____
Last First MI

Section 2

Annually, Blue Cross and Blue Shield of Kansas verifies whether or not your family has duplicate coverage. *If it has been a year since your last visit to this provider, please answer the following:*

1. Are you, your spouse or your dependent children enrolled in other group health insurance (**not** Medicare or SRS/Medicaid)? ☐ Yes ☐ No
   If Yes: Name of Policyholder _____
   Name, Address and phone number of other insurance company _____
   ID No., Group and/or Policy No. _____
   Employer/Group _____

We also attempt to verify if injuries, carpal tunnel, heart attacks, hernias and back problems are eligible to be covered by worker's compensation or auto insurance. If your visit is related to an injury or one of the conditions described above, please answer the following questions *unless this is a follow-up visit and you have been filled out this form previously.*

1. Date of accident or onset of symptoms _____
2. Description of injury (body part) or condition _____
3. How did this injury/condition occur? _____

Section 3

1. Where did it occur? ☐ School ☐ Home ☐ Work
   ☐ Other (explain)
   _____
1. Was your accident/condition work related? ☐ Yes ☐ No
   If Yes, are you self-employed? ☐ Yes ☐ No
1. Was the injury the result of a motor vehicle or of physical contact with a motor vehicle? ☐ Yes ☐ No
   If yes, type of vehicle involved: ☐ Car ☐ Truck ☐ Motorcycle
   If Motorcycle: a. Are you the owner? ☐ Yes ☐ No
   b. If you are the owner, does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? ☐ Yes ☐ No
1. Was another party responsible for your injury or condition? ☐ Yes ☐ No

Coordinating benefits places responsibility with a proper carrier, which helps keep rates lower for ou

Your signature required _____ **Date** / /

CONSENT TO TREAT:

I consent to the procedures which may be performed during my treatment and care at **ADVANCED THERAPY & SPORTS MEDICINE**, including emergency treatment or services. These may include, but are not limited to, any and all testing and measurements necessary for my evaluation, and any and all therapeutic procedures (exercise, joint metabolism, manual stretching, etc.) necessary for my treatment and under the direction and supervision of my therapist. I understand that is my right and responsibility to question freely any treatment, and in no way am I being guaranteed a certain result from the procedures rendered. That being noted, it is the responsibility of your therapist to practice current and reasonable experiential and evidence based methods.

Initials:_____

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT):

I hereby acknowledge that I have received a copy of the *Notice of Privacy Practices* for **ADVANCED THERAPY & SPORTS MEDICINE.** In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initials:_____

NOTICE OF FINANCIAL POLICY RECEIPT:

I hereby acknowledge that I have received a copy of the *Financial Policy* for **ADVANCED THERAPY & SPORTS MEDICINE** and agree to the terms and conditions of its contents

Initials:_____

NOTICE OF NO SHOW/CANCELLATION POLICY:

I hereby acknowledge that I have received a copy of the *No Show/Cancellation Policy* for **ADVANCED THERAPY & SPORTS MEDICINE** and agree to the terms and conditions of its contents

Initials:_____

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care. As a patient, you may want our facility to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS ASPECTS RELATED TO YOUR CARE. * Include your family physician if you are a self-referred patient. **

Name: _____ Relation to patient _____

Name: _____ Relation to patient _____

Name: _____ Relation to patient _____

I understand and have fully received & reviewed the contents of the Consent to Treatment, Notice of Privacy (HIPAA Acknowledgment/Consent), Financial Policy, and No Show/Cancellation Policies

_____ _____

Patient/Legal Guardian Signature Date

_____

Witness