COLON & RECTAL SURGEONS OF KANSAS CITY

7301 Mission Road, Building A Suite 237 Prairie Village, KS 66208
Phone: 913-677-4010 Fax: 913-677-1164

Please print. Please do not leave any blanks.

PATIENT (full name):______________________________
(First) *(Middle)* *(Last)*

DOB: ______________ SSN: ______________ AGE: ______

RACE: ☐ Asian ☐ Black ☐ White ☐ Other __________ ETHNICITY: ______________

SEX: ☐ MALE ☐ FEMALE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE

ADDRESS: ______________________ CITY: ______________

STATE: ____________ ZIP: ______________

PREFERRED PHONE: (___) ______________ ☐ HOME ☐ MOBILE ☐ WORK

SECONDARY PHONE: (___) ______________ ☐ HOME ☐ MOBILE ☐ WORK

Okay for office to leave message at PREFERRED number? ☐ Yes ☐ No

EMPLOYMENT STATUS: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Other
EMPLOYER: ____________ OCCUPATION: __________ PHONE: __________

EMERGENCY CONTACT: ______________ RELATION: __________
HOME: (____) ______________ CELL PHONE: (___) ______________

EMAIL ADDRESS FOR PATIENT PORTAL: ______________________

PRIMARY PHYSICIAN: ______________ PHONE: (___) ______________
REFERRING PHYSICIAN: ______________ PHONE: (___) ______________
CARDIOLOGIST *(if applicable)*: ______________ PHONE: (___) ______________

PRIMARY INS: ______________
GROUP #: ______________
ID#: ______________
POLICY HOLDER: ______________
RELATION: ______________
DOB: ______________
SSN: ______________
EMPLOYER: ______________
WORK PHONE: ______________

SECONDARY INS: ______________
GROUP #: ______________
ID#: ______________
POLICY HOLDER: ______________
RELATION: ______________
DOB: ______________
SSN: ______________
EMPLOYER: ______________
WORK PHONE: ______________

OVER

COLON & RECTAL SURGEONS OF KANSAS CITY
7301 Mission Road, Building A Suite 237 Prairie Village, KS 66208 (913) 677-4010 Fax:(913) 677-1164
www.crsurgeonskc.com

PREFERRED PHARMACY: Name: ______________________________

Address: ______________________ City/State/Zip: ________________

Phone: ______________________ Fax: ______________________

LAB PREFERRENCE: ______________________ Phone: ________________

Privacy Authorization Form

Colon & Rectal Surgeons of Kansas City has adopted a policy requiring their staff to obtain authorization from the patient to leave detailed messages if the patient is unavailable. This policy is to protect the privacy of the patient and also prohibit the staff of Colon & Rectal Surgeons of Kansas City from violating the patient's confidentiality. If there is not a signed consent on file, we will leave a message only stating our name and phone number. This message could be left on an answering machine, voicemail, or with a person answering the phone number a patient has provided.

By completing the consent form below, you are allowing the staff of Colon & Rectal Surgeons of Kansas City to leave a detailed message on an answering machine, voicemail, or with a specified individual.

I give my consent to the staff of Colon & Rectal Surgeons of Kansas City, P.A. to leave a message regarding treatment, test results, billing, or any other information necessary.

- ☐ Voicemail at home.
- ☐ Voicemail on a cell phone.
- ☐ Voicemail at work.
- ☐ I do not want messages left at home, work, or with any other person.

I give my consent to discuss clinical and medical details of my condition including (but not limited to): lab/test results, scheduling and other necessary information as necessary by the physician and/or staff of Colon & Rectal Surgeons of Kansas City.

May discuss/leave message with: ______________________ Relationship: ________________

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COPAYS, INSURANCE BILLING, FMLA/DISABILITY

All office copays are due at the time of service. Knowledge of insurance copays, coinsurance and deductibles is the responsibility of the person using the medical insurance. If your insurance requires a referral, it is YOUR responsibility to know and obtain this prior to coming in for an office visit and/or surgery. If you are unsure, you should contact your PCP or your insurance company directly. If you have Medicare or a supplemental insurance, we will not be collecting a copay at the time of service. We file insurance claims **ONLY** for companies that we are contracted with. **THIS OFFICE DOES NOT PARTICIPATE WITH KANSAS OR MISSOURI MEDICAID /FIRST GUARD, OR ANY OTHER MEDICAID PLANS OR ANY OF THE MARKET PLACE EXCHANGE PLANS.** Our office staff will not be able to answer detailed questions about your policy, as each plan is different. If we are not contracted with your insurance company, or if you are a private pay patient, all charges for examination, consultation and special procedures performed in the office are due and payable in full at the time services are rendered. Please discuss other necessary arrangements with our office manager **BEFORE** you see the doctor. We can provide you with an itemized receipt of your charges or payments. Please be sure to request this receipt before you leave. **We are happy to complete Disability and FMLA forms for you, however there is a fee of $35.00 for EACH set of forms completed. The fee must be made prior to completion. We will only complete the physician section.** You may fax (913-677-1164) or mail forms to our office.

Payment of the doctor's fee is a personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patients charge is not covered in part or in whole, by insurance. It is your responsibility to know what is and is not covered by your insurance company. Full payment is expected within 30 days after a response from your insurance company. Any statement not receiving payment after 30 days is considered past due. Regardless of performance by your insurance company, you are responsible for payment of your account. In the event that you default, you will be responsible to pay all reasonable collection costs including but not limited to attorney fees, and court costs.

- Signature________________________________ Date____________________

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICAN

I hereby authorize the release of any medical or other information necessary to process my claims. I also authorize payment of medical claims directly to Colon and Rectal Surgeons of KC for the services described on the attached claim form. Your signature below also releases our office to provide medical information to your disability/insurance company in compliance with HIPAA guidelines.

- Signature________________________________ Date____________________

MEDICARE CONSENT TO AGREEMENT

I request that payment for authorized insurance benefits be made in my behalf to Dr. Bruce Graham for any services. I authorize any holder of my medical information to release to the CMS, any information needed to determine benefits payable for related services. I authorize my insurance to furnish the above named doctor any information regarding my claims under Title VII of the Social Security Act. I agree that photographic copy of this authorization is as valid as the original.

- Signature________________________________ Date____________________

NOTICE OF PRIVACY ACT

I have received a copy of the Notice of Privacy Practice for Protected Health Information, which was effective May 1, 2013 from Colon and Rectal Surgeons of Kansas City.

- Signature________________________________ Date____________________