KANSAS CITY FAMILY MEDICAL CARE
1004 Carondelet Dr., Ste 300A, Kansas City, MO 64114

Primary Care Physician:

Patient Name:	Date of Birth:	Sex: M F	Date:
Patient Address:	City:	State:	Zip Code:
Marital Status (circle one): M S W D Sep. Other	Driver's License #:	Age:	Social Security Number:
Patient Home Phone:	Patient Work Phone:	Patient Cell Phone:	Email address:
Employer:	Occupation:	Status (circle one): Full-time Part-time Retired Unemployed Student	
Billing Address if different from Patient Address:	Referring Physician:	Referring Physician Phone:	
Spouse's Name:	Spouse's Date of Birth:	Spouse's Social Security #:	Spouse's Work Phone #:
Preferred Pharmacy:	Preferred Pharmacy Address:		Preferred Pharmacy Phone #:
WHO REFERRED YOU TO OUR OFFICE?	Primary Language		

INSURANCE INFORMATION

Race:
African American
American Indian
Asian
Caucasian
Hispanic
Other
Unknown

Ethnicity:
Non- Hispanic
Hispanic

Religion:
Buddhist
Catholic
Hindu
Islam
Jewish
N/A
Other
Protestant

Primary Insurance Name:			Insurance Coverage Start Date:
Insurance ID #:		Group #:	
Insurance Address:	City:	State:	Zip:
Subscriber Name:	DOB:	Sex: M F	Relationship to Subscriber:
Subscriber Address (if different from patient):			
Secondary Insurance Name:			Insurance Coverage Start Date:
Insurance ID #:		Group #:	
Insurance Address:	City:	State:	Zip:
Subscriber Name:	DOB:	Sex: M F	Relationship to Subscriber:
Subscriber Address (if different from patient):			

NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE & OTHER THAN YOUR ADDRESS)

Name:	DOB:		Relationship:	
Address:				
City:	State:	Zip:	Work Phone:	Home Phone:

ASSIGNMENT OF BENEFITS | **SIGNATURE REQUESTED IN 4 PLACES**

Please remember that insurance contracts are made between the patient and the insurance company. Often the insurance does not provide full payment of medical costs. Payment of the bill is, therefore, your responsibility. Any accounts over 91 days will be assessed a 1% finance charge. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize payment of medical benefits to KANSAS CITY FAMILY MEDICAL CARE for services rendered to myself.

Signed x: _____ **Date:** _____

"SIGNATURE OF FILE" will automatically print on your claim form, allowing your insurance to pay us directly.

RECORDS RELEASE : I hereby authorize the release of any information, including medical and billing information, by KANSAS CITY FAMILY MEDICAL CARE, to referring doctor and insurance company.

Signed x: _____ **Date:** _____

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to: KANSAS CITY FAMILY MEDICAL CARE for any services furnished to me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed x: _____ **Date:** _____

E-PRESCRIBE AUTHORIZATION: I hereby authorize KANSAS CITY FAMILY MEDICAL CARE to access my medication records electronically.

Kansas City Family Medical Care

Patient Rights and Notification of Physician Ownership

AS A PATIENT OF Kansas City Family Medical Care, YOU HAVE THE FOLLOWING RIGHTS.

PATIENT'S BILL OF RIGHTS:
EVERY PATIENT HAS THE RIGHT TO BE TREATED AS AN INDIVIDUAL WITH HIS/HER RIGHTS RESPECTED. THE FACILITY AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT'S RIGHTS:

PATIENT RIGHTS:
• To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
• To be treated with respect, consideration, and dignity in receiving care, treatment, tests.
• To be provided privacy and security of self and belongings 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 tests 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, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
• Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
• Confidential treatment of all communications and records pertaining to his/her care. 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 practice has established policies to govern access and duplication of patient records.
• Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
• 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.
• Know which practice rules and policies apply to his/her conduct while a patient.
• 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 usual care. The patient's written consent for participation in research shall be obtained and retained in his/her patient record.
• Examine and receive an explanation of his/her bill regardless of source of payment.
• To appropriate assessment and management of pain.
• Patients are informed of their right to change providers if other qualified providers are available.

If you need a translator:
If you will need a translator, **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 visit.

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 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 preformed
- Confidentiality of personal medical information

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

Submission and Investigation of Grievances: You have the right to have your verbal or written grievances submitted, Investigated and to receive a written notice of the practice's decision. The following are the names and/or agencies you may contact:

Practice Administrator
1004 Carondelet Dr., Ste 300A,
Kansas City, MO 64114
816-941-9030

Sites for address and phone numbers of regulatory agencies: Medicare Ombudsman website
www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-392-0210

Office of the Inspector General: http://oig.hhs.gov

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of your office visit or test and have decided to have your office visit or test performed at this practice.

_____ _____

Signature of Patient or Patient Legal Representative Date

KANSAS CITY FAMILY MEDICAL CARE
ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES 2013

I acknowledge that I have received a copy of the Facility's "Notice of Privacy Practices" with the effective date of 9/23/13.

_____ _____
Signature of Patient/Personal Representative Date

_____ _____
Relationship to Patient Print Patient's Name

For Staff Use Only

The above named Patient/Personal Representative was provided with a copy of the "Notice of Privacy Practices." A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify):_____
_____
_____

Signature of Staff Member Completing Form:

_____ _____
Date

Original to be maintained in Patient's medical record