KANSAS SURGICAL
CONSULTANTS, LLP

Patient Information

Referring Physician:_____ Family Physician:_____

Patient Name:_____ Date of Birth: _____ Age: _____
(Last) (First) (Middle Initial)

Street Address:_____City:_____ State:_____ Zip:_____

SSN:_____ □ Male □Female Status: □Single □Married □Divorced □Widowed

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Please check which number(s) we may call you at? □ Home □ Work □ Cell

And/or leave a message at? □ Home □ Work □ Cell

□Employed □Unemployed □Retired

Employer:_____Employer Address: _____

Spouse Name: _____Date of Birth: _____
(Last) (First) (Middle Initial)

Spouse's employer: _____ Employer Phone Number: _____

Insurance Policy Holder Information

PRIMARY COMPANY:_____SECONDARY COMPANY:_____

Subscriber's Name:_____Subscriber's Name: _____

Subscriber's Date of Birth: _____Subscriber's Date of Birth: _____

Subscriber's Employer: _____ Subscriber's Employer: _____

ID #: _____ID#: _____

Group #_____ Group#:_____

Guarantor (Responsible Party)

Responsible Party:_____ Responsible Party Date of Birth:_____

Address: _____

Relation to patient: _____ SS#: _____Home Phone: _____

Responsible Party Employer: _____ Work Phone: _____

Emergency Contact

Emergency Contact: _____Relationship: _____Phone: _____

Emergency Contact: _____Relationship: _____Phone: _____

Patient Demographics

If you would like a written summary from today's visit (clinical summary), please inform the receptionist.

Please answer the following questions so we may comply with the Meaningful Use regulations:

1. Race: (Please choose one)
   - ☐ White, Not Hispanic or Latino
   - ☐ Black or African American, Not Hispanic or Latino
   - ☐ Asian
   - ☐ Native Hawaiian
   - ☐ Other Pacific Islander
   - ☐ American Indian or Alaskan Native
   - ☐ Hispanic or Latino (all races)

2. Ethnicity: (Please choose one)
   - ☐ Hispanic or Latino
   - ☐ Non-Hispanic or Latino

3. Preferred Language (Please choose one)
   - ☐ English
   - ☐ Spanish
   - ☐ Other: _____

4. Preferred Method of Communication (Please choose one)
   - ☐ Email
   - ☐ US Post Office
   - ☐ Home Telephone
   - ☐ Cell Phone

5. Email address (to be used for secure patient communication only): _____

Assignment and Financial Responsibility

I hereby assign payment directly to Kansas Surgical Consultants, L.L.P. for surgical and/or medical benefits. I acknowledge that I accept full responsibility for any medical service rendered to me or anyone for whom I am legally responsible for. I understand that I am financially responsible for charges even when insurance should provide coverage and does not pay a valid claim within 60 days, or for non-covered services. I will be legally responsible for all collection costs involved with this account including all return check fees, court costs, attorney fees and other expenses incurred with collection if I default on this agreement. **I have received a copy of the KSC Financial Policy and agree to its terms. I acknowledge that the Notice of Privacy Practices of Kansas Surgical Consultants have been offered to me and are available upon request at any time.**

_____ _____

Patient Signature (or guarantor if minor) Date

_____

Patient Name (printed)

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Authorization When Patient Requests Use or Disclosure of Protected Health Information

I hereby authorize Kansas Surgical Consultants to disclose any of the following information: Any medical treatment regarding billing issues, appointment concerns, and medical records related to my care as if I were the person calling or inquiring.

Please list the name and relationship of the people you wish to have this access.

Name	Relationship	Phone

I understand I have a right to revoke the authorization in writing except to the extent Kansas Surgical Consultants has taken action or has relied on the authorization. This authorization may be revoked by my requesting revocation in writing and delivering a copy of the same to Kansas Surgical Consultants.

The information used or disclosed under the authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy laws.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Printed Name of Patient Relationship to Patient

****

A good faith effort was made to obtain a written acknowledgement of his/her receipt of the Notice, but such acknowledgement 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 acknowledgement will be made at the next opportunity ❒Other_____

Signature of Workforce member completing form:_____Date:_____

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PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible care, and your understanding of our Patient Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your financial responsibilities. Carefully review the following information:

PAYMENT POLICY

We require a copy of your insurance card(s), photo identification and credit, debit or ACH authorization on file prior to treatment. We will attempt to verify your benefits on each visit. It is our goal to provide you with the most accurate information about your referrals, prior authorizations, co-pays and co-insurance responsibilities. If you have insurance, you will receive an explanation of benefits from your insurance carrier, which will show your responsibility (amount owed). The practice will send you a patient due statement once your insurance explanation of benefits has been processed. Payment is expected within 15 days of your statement date. The amount charged to your payment method on file will be based on the agreed upon authorization (separate document). You will have the option of paying your balance in full, or making monthly (automated) payments. We accept Visa, Mastercard, Discover and American Express.

If you do not have health insurance we expect payment at the time of the service. **A payment of $200.00 is due at the time of your initial visit. If you are unprepared to pay the $200.00, your visit will be rescheduled.** We do offer financial discounts for uninsured patients who may need surgery. A financial agreement will be obtained prior to services being performed. Please contact our business office at 316-651-5860 if you have any questions.

Please be aware our returned check fee is $35.00.

BILLING AND INSURANCE

We participate with most local and many national insurance plans. However, it is your responsibility to understand whether your insurance has limits on the doctors you can see, or the services you can receive. If you are covered by health insurance, you should be prepared to show the most recent copy of your insurance card at every office visit. As a courtesy, we will file your claim with your primary and secondary insurance plans if you provide complete and accurate information about your insurance. You will be responsible for deductibles, co-payments, non-covered services, co-insurance and items considered “not medically” necessary by your insurance company. If you do not have health insurance, payment is due at the time of service.

If your insurance company pays you directly, you should receive payment within 30 days of billing. You will be responsible for full charges until Kansas Surgical Consultants, LLP receives the insurance check and summary of claims processed from the insured patient. After 60 days, if we have not heard from you, accounts will be considered for collections and we will expect payment of the full charges.

REFERRALS

If your insurance policy is an HMO and you are referred to our office, we will do our best to help you obtain any referral forms required by your insurance provider. If we are unable to obtain the referral for any reason, we will let you know. It will then be your responsibility to contact your primary care physician and obtain the referral prior to your appointment. Failure to obtain a referral may result in a reduction of benefits or non-payment by your insurance provider.

WORKER'S COMPENSATION
If your office visit is due to an injury at work that has been reported to and verified by your employer, you may be eligible to have your claim covered by Worker's Compensation insurance. Be sure to inform our receptionist that the injury occurred while on the job. You will need to provide all claim information and complete a form in order for us to file this claim correctly.

ACCIDENTS AND INJURIES
All medical expenses that result from a vehicle accident or public liability are considered the personal responsibility of the patient.

USUAL, CUSTOMARY, AND REASONABLE
Insurance companies pay an established percentage of the physician's fee or pay the insurance plan's customary or reasonable fees, whichever is less. Although these limits are called customary, they may or may not reflect the fees that physicians charge. You may also notice that on your invoice, the fee your physician has charged is higher than the reimbursement from your insurance company. This does not mean your physician is overcharging you for those services. The insurance company may not have taken into account up-to-date, regional data in determining the amount paid for services. There is no regulation on how insurance companies determine the amount paid for services. The language used in this process may be inconsistent among insurance companies and difficult to understand.

UNDERSTANDING YOUR HEALTHCARE
Our office and surgery charge is determined after each visit and procedure. You, your doctor, or your insurance company may call us to obtain an estimate of the approximate charges in advance of the service. Please be aware that you will receive separate billing from other providers or entities related to your surgical services or procedure (radiologist, anesthesiologists, pathologists, surgeons, etc.) as well as facility fees.

FORMS AND RECORDS
The completion of disability forms and FMLA forms will incur a $15.00 administrative charge per set of forms. Forms will not be completed by KSC until payment is received. There is no charge for duplication of medical records sent directly to another medical provider or records requested by your standard health insurance carrier. Duplication of medical records for personal use, disability policies, life insurance policies, or cancer policies will incur a charge.

COLLECTIONS PROCESS
If we do not receive your payment in full within sixty (60) days of your first mailed statement, and you have not made arrangements with our business office, your account will be considered delinquent and considered for collection action.

If your account is placed in collections you will be charged collection fees including but not limited to agency fees, attorney fees and court costs.

If you have any questions, please call 316.651.5860 and ask to speak with our business office personnel. We want to help you understand your healthcare billing.

I authorize KSC to release my information including the diagnosis and the records of any treatment or evaluation rendered to third party payers and or health practitioners. I authorize and request my insurance companies to pay KSC directly insurance benefits otherwise payable to me. I understand that my insurance may pay less than the actual bill for services. I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance on the account including service, and any additional charges as mentioned above that may be incurred. I have read and understand this agreement.

Patient Signature: _____ ***Date:*** _____ ***Date of Birth:*** _____

A copy will be provided for your records upon request.

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Notice of Privacy Practices Summary

Maintaining privacy of your health information is very important to us. Our website (www.kansassurgicalconsultants.com) and our reception staff will provide you with our *Notice of Privacy Practices.* The following is a brief summary of the content of the policy. We encourage you to read the entire Notice and ask any questions you may have regarding its contents.

Uses and Disclosures of Your Health Information That May Be Made Without Your Authorization. This section describes the different ways we may use or disclose your health information without first obtaining a specific authorization from you. These types of uses and disclosures are specifically permitted by law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the functioning of our health care system.

Your Health Information Rights. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to access
- Right to request amendment
- Right to and accounting disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to be notified of a breach of your protected health information
- Right to receive a paper copy of our Notice of Privacy Practices

How to File Complaints Concerning Our Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing a complaint.

I acknowledge that the Notice of Privacy Practices of Kansas Surgical Consultants with the effective date of September 23, 2013 has been given or offered to me and are available upon request at any time.

_____ _____
Patient Name (Printed) Patient/Personal Representative Signature

_____ _____
Relationship to Patient Date

****

A good faith effort was made to obtain a written acknowledgement of his/her receipt of the Notice, but such acknowledgement 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 acknowledgement will be made at the next opportunity ❒Other_____

Signature of Workforce member completing form:_____Date:_____

Patient Name: _____ Date of Birth:_____

Welcome to The Breast Center by Kansas Surgical Consultants. In order to provide the best care we need to know your medical history. Please take a few minutes to answer all questions. Please add any information you feel will help explain your health. If you need any help with this form please ask us. Thank you

Today's Date_____ Age_____ Height_____ Weight_____ Bra Size _____

Who referred you to our practice?_____

Have any of your family members been treated here?_____

Who is your Family Physician? _____

Please list any other doctors you wish us to communicate with? _____

BREAST HISTORY

Check the box if you have had:

- ☐ Breast Pain
- ☐ Breast Discharge
- ☐ A breast mass you can feel
- ☐ Abnormal Mammogram
- ☐ A Recent biopsy
- ☐ Other_____

Check all that apply to you:

- ☐ Breast Cancer prior to age 50
- ☐ Breast Cancer after age 50
- ☐ Bilateral Breast Cancer
- ☐ Breast and Ovarian Cancer
- ☐ Ovarian Cancer at any age
- ☐ Male Breast Cancer any age
- ☐ Relative with BRCA mutation
- ☐ Strong family history of Breast/Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Ashkenaz/Eastern European Jewish Descent

MEDICAL CONDITIONS (adults only) (Review of Systems)

Have you had any of the following? If yes please check, if no problems check the no problems box.

General Health

- ☐ Recurrent infections ☐ Recurrent fever ☐ Fatigue
- ☐ Night sweats ☐ Recent weight gain ☐ Recent weight loss
- ☐ Decreased appetite ☐ No Problems

Comments _____

Skin

- ☐ Sores ☐ Hair Loss ☐ Non-Healing wound
- ☐ Changes in moles ☐ New lesions ☐ Burn Trauma
- ☐ Rash ☐ Lumps/growths ☐ No problems

Comments _____

Head, Ears, Eyes, Nose, Mouth, Throat

- ☐ Ear infections ☐ Nose bleeding ☐ Cataracts
- ☐ Sore throat ☐ Seasonal allergies ☐ Eye infections
- ☐ Headaches ☐ Corrective Lenses ☐ Blurred Vision
- ☐ No problems

Comments _____

Lung

- ☐ Difficulty breathing ☐ Cough ☐ Sleep on more than 1 pillow
- ☐ Cough blood or mucus ☐ Wheezing ☐ No problems

Comments_____

Patient Name: _____ **Date of Birth:**_____

Breast

☐	Breast lump/mass	☐	Nipple discharge	☐	No problems
☐	Breast pain	☐	Nipple pain		
☐	Breast swelling	☐	Skin changes		

Comments_____

Heart

☐	Chest pain	☐	Tightness	☐	Thumping or pounding
☐	Heart murmur	☐	Swollen arms or legs	☐	Shortness of breath
☐	Rheumatic fever	☐	High blood pressure	☐	No problems

Comments_____

Stomach and Intestinal

☐	Special diet	☐	Heartburn	☐	Rectal Bleeding
☐	Nausea	☐	Indigestion	☐	Blood in stool
☐	Vomiting	☐	Black Stools	☐	Positive hemoccult
☐	Ulcers	☐	Constipation	☐	Diverticulosis
☐	Difficulty swallowing	☐	Diarrhea	☐	Diverticulitis
				☐	No problems

Comments_____

Male Reproductive

☐	Painful Urination	☐	Frequency	☐	Impotence
☐	Prostate problems	☐	Urgency	☐	Testicular Pain
				☐	No Problems

Comments_____

Female Reproductive

☐	Painful urination	☐	Frequency	☐	Blood Clots
☐	Irregular Periods	☐	Urgency	☐	No problems

Comments _____

Muscle, Bone, Joint

☐	Joint Pain	☐	Neck Pain	☐	Muscle cramping
☐	Muscle Pain	☐	Joint stiffness	☐	No problems
☐	Back pain	☐	Joint swelling		

Comments_____

Nervous System

☐	Seizures	☐	Decreased memory	☐	Problem speaking
☐	Dizziness	☐	Fainting	☐	Problems moving
☐	Loss of consciousness			☐	No problems

Comments_____

Veins (blood vessels), Lymphatic

☐	Abnormal bleeding	☐	Easy Bruising	☐	No problems
☐	Anemia	☐	Enlarged lymph nodes		

Comments_____

Patient Name: _____ Date of Birth:_____

ALLERGIES

Are you allergic to any medications, prescribed or over the counter? □ Yes □ No

If yes, please list medication and the reaction you had. (Include aspirin, Tylenol, vitamins, over the counter medications, herbal remedies, supplements etc.)_____

Are you allergic to any contacts such as **latex,** adhesive tape or betadine? □ Yes □ No

If yes, please list the contact and the reaction you had._____

Are you allergic to any foods? □ Yes □ No

If yes, please list food and the reaction you had._____

FAMILY HISTORY

Are there diseases or illnesses that family members have had? Please check the boxes below for any family member who has had the problem. **Under siblings please write brother or sister**. **Under Grandmother please write maternal (mother)or paternal (father). Under Grandfather please write maternal (mother) or paternal (father).**

	Mother	Father	Siblings	Grandmother	Grandfather	Children	Cousins	Aunt	Uncle
Anesthetic Problems									
Cancer -Breast									
Cancer -Colon									
Cancer–Endometrial									
Cancer- Ovarian									
Cancer- Pancreatic									
Cancer-Other									
Diabetes									
Heart Disease									
High Blood Pressure									
Melanoma									
Mental Illness									
Stroke									

Comments _____

WOMEN'S HISTORY

These questions help assess your individual risk for developing breast cancer:

Date or age of first menstrual period? _____ Have you reached menopause?_____ At what age?_____

How old were you when you had your 1st child? _____

Number of pregnancies?_____ Number of live births?_____

Do you do regular self breast exams? □ Yes □ No **Date of last mammogram?**_____

Have you ever had a breast biopsy? □ Yes □ No If yes, how many? _____

If yes, which breast? □ Right □ Left When date was this performed? _____

Patient Name: _____ Date of Birth:_____

Were there any abnormal cells on the biopsy? □ Yes □ No If yes, please mark the following:

□ Atypical Ductal Hyperplasia □ Breast grouped/clustered calcifications

□ Lobular Carcinoma Insitu (LCIS)

Are you taking Hormone Replacement Therapy? □ Yes □ No If yes, how long? _____

Have you taken Hormone Replacement Therapy? □ Yes □ No If yes, when did you stop? _____

Have you or any family member been tested for a **BRCA** mutation? □ Yes □ No

How many of the woman's a first-degree relative have had breast cancer?

□ Mother □ Sisters □ Daughters

PAST MEDICAL HISTORY

Please list any **SURGERIES** you have had and the year they were performed.

_____

_____

_____

Have you ever had a **colonoscopy**? □ Yes □ No
If yes, please list the date and results. _____

Have you had any **serious injuries**? □ Yes □ No
If yes, please list the date and type of injury. _____

Do you currently have any of the following medical problems?

□ Heart Disease	□ Ulcers	□ Depression	□ Cancer, type_____
□ Diabetes	□ Epilepsy	□ Kidney Disease	□ Hepatitis A B C Other
□ High Blood Pressure	□ HIV	□ Jaundice	□ Pneumonia
□ Stroke	□ Anemia	□ Lung Disease	□ Hypothyroidism
□ Cataracts	□ Colitis	□ Glaucoma	□ Headaches
□ AIDS	□ Leukemia	□ Reflux	□ Hyperthyroidism
	□ Sleep Apnea	□ High Cholesterol	

Please list any **other health problems** you have:

_____

_____

SOCIAL HISTORY

What is your marital status? □ Married □ Single □ Divorced □ Widowed
What is your occupation (if retired your past occupation)? _____
Do you use NICOTINE products? □ No □ Smoke □ E-Cig/Vape □ Chewing Tobacco
Have you ever used Nicotine products? □ No □ Smoke □ E-Cig/Vape □ Chewing Tobacco
Do you drink alcoholic drinks? □ Yes □ No If yes, how much and how often?_____
Do you take any drugs for reasons that are not medical? □ Yes □ No
If yes, please list _____

Patient Name: _____ Date of Birth:_____

MEDICATIONS/OVER THE COUNTER/SUPPLEMENTS

Do you take any medicine (prescribed, herbal, over the counter, or health supplements)? □ Yes □ No

If yes, please list below:

Medication	Dosage	How often	What do you take it for?

Do you take blood thinners? □ Yes □ No

Do you take Metformin? □ Yes □ No

Do you take Aspirin daily? □ Yes □ No

Do you take diet pills? □ Yes □ No

Do you take Vitamin E? □ Yes □ No

Do you use a C-Pap machine? □ Yes □ No

Do you take Glucophage? □ Yes □ No

Do you take St. John's Wort? □ Yes □ No

Do you take fish oil? □ Yes □ No

OTHER INFORMATION Please write below any other information you feel the doctor should know. _____