KANSAS PEDIATRIC NEUROLOGY

PATIENT INFORMATION

Please Fill Out Completely

• New Patient Date: _____

• Update only

Personal Information

Name: _____

Sex: _____ SSN: _____ Date of Birth: _____

Address: _____

City/St.Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: _____ State: _____ Religion: _____

Email Address: _____ Primary Language: _____

Check all that apply:

• Full-Time • Part-Time • Not Employed • Student Full-Time • Student Part-Time

• Active Duty Military • Self-Employed • Retired

Employer Name: _____ Employer Phone: _____

Employer Address: _____

City/St.Zip: _____

Primary Care Physician: _____

Responsible Party (person responsible for billing)

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Sex: _____ SSN: _____

Address: _____

Home Phone: _____ Employement Status: • FT • PT Other: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Communication

I wish to be contacted in the following manner: (check all that apply)

Home/CellPhone	• OK to leave detailed message	• Only leave message to call back
Written	• OK to mail my home address	• OK to make my work/office
Work Phone	• OK to leave detailed message	• Only leave message to call back

Patient Disclosure preferences

You are here by authorized to furnish any or all medical and insurance information concerning my medical/physical condition, treatment and test results to the following:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

- I understand my signature requests that payment be made to the provider and authorizes the release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original.
- I have received and agreed to Kansas Pediatric Neurology Center Financial Policy.
- The information provided on this form is accurate to the best of my knowledge
- I hereby acknowledge that | have received a copy of this clinics Notice of Privacy Practices.
- My signature on this date acknowledges my receipt of the brochure on Billing Practices.
- I express consent that Kansas Pediatric Neurology Center, its providers and agents, in order to manage my account and/or collect any amounts owed for services rendered may place telephone calls to my cellular, resident or other telephone number(s) associated with my account, including those I have provided or which may be available.
- Further I acknowledge and expressly consent Kansas Pediatric Neurology Center, its providers and agents, to utilize artificial or pre-recorded voice or auto-dialing technologies for any of these stated purposes or other permissible purposes.
  TCPA Decline •

_____ _____ _____

Patient Signature Date Time

_____ _____

Parent/Guardian Signature Relationship to Patient

Primary Insurance (please enter information as it appears on your card)

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Sex: _____ SSN: _____

Address: _____

Home Phone: _____ Employment Status: • FT • PT Other: _____

Employer: _____ Employer Phone: _____

Employer address: _____

Insurance Co. Name: _____ Policy #: _____

Group # _____ CoPay $ _____

Secondary Insurance (please enter information as it appears on your card)

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Sex: _____ SSN: _____

Address: _____

Home Phone: _____ Employment Status: • FT • PT Other: _____

Employer: _____ Employer Phone: _____

Employer address: _____

Insurance Co. Name: _____ Policy #: _____

Group # _____ CoPay $ _____

Patient/Emergency Contacts

Name _____ Relationship to Patient _____

Home Phone _____ Other Phone _____

Next of Kin

Name _____ Relationship to Patient _____

Home Phone _____ Other Phone _____

Patient Restriction of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The Individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as correspondence to the individual's office, instead of the individual's home.

NO SHOW/ MISSED APPOINTMENT POLICY

We at Kansas Pediatric Neurology Center, understand that sometimes you may need to cancel or reschedule your appointment and that emergencies may arise. If you are unable to keep your appointment, please notify our office at 316-796-5610 as soon as possible.

To ensure each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each scheduled patient to attend their visits on time. Asa courtesy, an appointment reminder automated call is made to you / attempted two business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY INFORMATION

1. Appointments should be cancelled with at least a 24 hour notice.
2. If less than a 24 hour cancellation is given this will be documented as a “No Show” appointment.
3. If you do no present to the office for your appointment within 15 minutes of your scheduled appointment time, this will be documented as a "No Show” appointment.
4. If you incur three “No show/Missed” Appointments within a one year time period, you may be dismissed frorn the clinic.
5. After the second “No Show/Missed” appointment, the Kansas Pediatric Neurology Center will remind you of our policy by letter.

I have read or have been informed of the Kansas Pediatric Neurology Center's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office as outlined above, if | have difficulty fulfilling my scheduled appointments.

Patient Name	Date of Birth	Today's Date

Patient Signature or Parent/Guardian	Relationship to Patient

HIPAA Privacy and Release of Information Authorization

Patient Name: _____
Patient ID: _____
Patient DOB: _____

I, _____ hereby authorize _____ and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.
If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____

Patient Printed Name Date

_____

Patient Signature

KANSAS PEDIATRIC NEUROLOGY CENTER WT:
Dr, Bassem El-Nabbout, MD HR:
02:

PATIENT NAME: _____
PATIENT DOB: _____ DOS:_____/_____/_____
DIAGNOSIS: _____ CODE: _____

LABS: ENTERED IN SYSTEM NEED TO ENTER ORDERS:
NO LAB TODAY

SCHEDULE:
MRI/BRAIN IVIRI/SPINE CT EEG EMG VEEG BOTOX
GENETIC NEURO PSYCH BEHAVIOR/DEVELOPMENTAL
WITH CONTRAST WITHOUT CONTRAST OTHER:
WITH SEDATION WITHOUT SEDATION

SCHEDULED FOR:
SCHEDULED AT:
DIAGNOSIS:
FOLLOW UP APPOINTMENTS:
IN: DAYS / WEEKS / MONTHS / YEARS

SIGNATURE:

NOTIFY PA DOC *
LETTER ORDERS SOV PA#