Primary Care Associates

PATIENT REGISTRATION

DR_____ DATE_____

PATIENT INFO

NAME - LAST	FIRST	MIDDLE	BIRTH DATE	AGE	SEX	SS #
STREET ADDRESS			HOME PHONE ( )			WORK PHONE ( )
CITY	STATE	ZIP CODE	CELL PHONE ( )			EMAIL
EMPLOYER			STUDENT (CHECK ONE) ☐ YES ☐ NO			MARITAL STATUS
ADDRESS			SPOUSE NAME			SPOUSE EMPLOYER ( )
CITY	STATE	ZIP CODE	SPOUSE CELL PHONE ( )			SPOUSE WORK PHONE

GUARANTOR

NAME		EMPLOYER	
ADDRESS		ADDRESS	
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE
RELATION TO PATIENT		WORK PHONE	
HOME PHONE		**MUST COMPLETE: IN CASE OF EMERGENCY, NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU**	
SOCIAL SECURITY NUMBER	D.O.B.	PHONE	RELATIONSHIP

INSURANCE

INSURANCE (Please check one):
☐ No Coverage ☐ Auto Insurance ☐ BCBS ☐ CHAMPUS ☐ HMO ☐ Medicaid ☐ Medicare ☐ PPO ☐ Workman's Comp. ☐ Other

PRIMARY COMPANY			**SECONDARY COMPANY**		
ADDRESS			ADDRESS		
CITY, STATE	ZIP CODE		CITY, STATE	ZIP CODE	
SUBSCRIBER'S NAME	D.O.B.	SEX	SUBSCRIBER'S NAME	D.O.B.	SEX
POLICY #			POLICY #		
ID #	GROUP #		ID #	GROUP #	
SS #	RELATION TO PATIENT		SS #	RELATION TO PATIENT	

REFERRAL INFO

REFERRING PHYSICIAN - (CHECK BOX IF REFERRED THRU ER) ☐ ER		CITY, STATE	
ACCIDENT ☐ YES ☐ NO	ACCIDENT OCCURRED ☐ WORK ☐ HOME ☐ AUTO ☐ OTHER	ACCIDENT STATE	ACCIDENT DATE
REASON FOR SEEING DOCTOR			
ATTY INVOLVED ☐ YES ☐ NO	IF YES, ATTORNEY'S NAME AND PHONE NUMBER		

SIGNATURES

RELEASE OF MEDICAL INFORMATION

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to Primary Care Associates, LLC, for the medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to Primary Care Associates, LLC, for those services.

INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize Primary Care Associates, LLC, to release any information acquired in the course of my examination or treatment to my doctor, referring doctor, and/or my insurance company or employer.

FINANCIAL AGREEMENT: I understand that I am responsible for all fees, regardless of insurance coverage. See separate Financial Policy/Agreement.

PATIENT'S SIGNATURE: _____ DATE _____

INSURED'S SIGNATURE: _____ DATE _____
(if other than patient)

FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. Please understand that payment of your bill is part of your care. To help avoid misunderstandings, we have provided you with details of our financial policy below.

Insurance. We participate with most insurance plans. ***If you are not insured by a plan we accept, payment in full is expected at each visit.*** *If you do not have your current insurance card with you, payment in full for each visit is required until we verify coverage.* ***Knowing your insurance benefits plan is your responsibility.*** *It is your responsibility to make sure the correct in-network facility is used for all test and hospital encounters. Contact your insurance company with questions you may have regarding your coverage.*

A coordination of benefits from (COB) must be filled out annually and returned to your insurance company Failure to return this information will result in you being responsible for all charges.

Co-payments and Payments. *All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.*

We accept payment by cash, check, VISA, MasterCard, Discover or American Express. We do accept payments on-line on our website at www.pca-wichita.com. **All previous balances must be paid at time of service, unless prior arrangements have been made with the billing department.** If a check is returned for insufficient funds or payment has been stopped, you will be charged a $30 fee in addition to the amount of the check. If you have a second check returned, you will be asked to pay by cash, money order, cashier's check, or credit card for future visits.

Self-Pay. A minimum of a $50 for existing patients and $100 for new patients is due prior to treatment from all uninsured patients. You must pay your visit in full prior to being scheduled again. You will receive 35% discount if paying your entire balance that day **(DOT physicals excluded).** The balance is the best estimate and there could be additional charges after your visit. If you have paid in full on the date of service, you can still receives 35% discount on the remaining balance.

Co-insurance and deductibles. You may be asked to pay your visit in full due to your deductible. Otherwise, your co-insurance and/or deductible balance is due when you receive your explanation of benefits from your insurance company.

Minor Patients. The following patients are responsible for payment of all minor patient balances: the adult accompanying the minor and the parents (or guardians.). We do not recognize domestic judgments including custody agreements.

Non-covered services. Please be aware that some of the services you receive may be non-covered or considered not reasonable or necessary by Medicare or other insurers. Payment in full is required at time of serivce. ***PCA gives a 35% discount for paying in full that day.*** If the total cost of the visit is not able to be determined, you will be asked for an estimated payment, then billed or credited the difference. We will work with you to settle your account. Ask to speak with our billing staff if you need assistance regarding an extended payment schedule. ***DOT physicals are typically not covered by insurance and is excluded from the 35% discount.***

Sports, camp, and work physicals are not covered by many insurance companies. "Sports Physicals" should not replace the annual well-child exam. We can complete a clearance form at the time of your child's well-child exam. We recommend a sports physicals be provided in the context of a full preventive visit.

Proof of insurance and Claims Submission. All patients must complete our patient information form periodically prior to seeing the doctor. ***PCA policy is to obtain a copy of your driver's license, insurance card, social security number as well as the guarantor's social security number.*** We will submit your claims and assist you in order to help get your claims paid. ***In order to submit claims we must have the policyholder's date of birth.*** We file supplemental insurances when appropriate. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit. If your insurance company does not pay your claim in a timely manner, the balance will be your responsibility.

Nonpayment. If your account becomes delinquent, you agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. After you have received two statements and your account is over 120 days past due, you will receive a letter stating that you now have 10 days to pay your account in full. Payment plans may not exceed a 6 month time period, unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency or a collection attorney and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. Our policy is to charge for missed appointments not cancelled within 24 hours to your appointment. There will be a $25 charge after the third missed appointment. These changes will be your responsibility and billed directly to you. *Please help us to serve you better by keeping your regularly scheduled appointment*

Worker's Compensation or Motor Vehicle Accidents: *It is your responsibility to file a report with your employer or automobile insurance.* If you are injured on the job, please let the receptionist know so we may contact your employer to facilitate filing your claim. If you are injured in a motor vehicle accident, please bring your automobile insurance card. Until your MVA claim is settled, you will be held responsible for your charges. We will be happy to refund any money received from your auto insurance carrier.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Sign: _____ Date: _____

Primary Care Associates

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

New federal legislation under the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) limits with whom we can discuss your health information. If there is a person or persons with whom you would like us to be able to discuss you or your dependent's health information, you ***must*** designate them below.

If you, your spouse or your children ever want to call Primary Care Associates on behalf of another family member (over age 18) or want another family member to call on your behalf, **you must sign and date this form.**

Patient Name:	Date of Birth:
Patient Address:	

1. I authorize Primary Care Associates to discuss or release information identified in paragraph 2, below, to the following individuals:

Names(s) of authorized person(s)	**Relationship to patient**

2. I authorize Primary Care Associates to discuss or release information necessary to process or respond to treatment, coverage/benefit inquires, claims inquiries, appeals, health care operations and/or questions about my health care and I acknowledge that the information released may include individually identifiable health information about me.

3. This authorization is being made at my request.

4. In signing this authorization, I understand and acknowledge the following (initial in the space provided):
   _____ I understand that this authorization is voluntary and that I may refuse to sign it.
   _____ I understand that I my refusal to sign this authorization will not affect my ability to obtain treatment.
   _____ I understand that I may revoke this authorization at any time by notifying Primary Care Associates in writing and all future disclosures will then cease. However, such revocation shall not affect any disclosures we have already made reliance on your prior Consent.
   _____ I, understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.
   _____ I, understand that, unless otherwise revoked, **this authorization will expire one year from the date** I sign it, as required by Kansas Law and will remain a part of my medical record.
   _____ I understand as a patient, I have a right to restrict the uses of this information but the Practice does not have to agree to those restrictions.

_____ _____

Date Signature of Patient/Legal Representative

Legal Representative

Address:_____ Telephone Number:_____

Relationship to Patient:_____

Primary Care Associates

Jeffery Davis, MD
Paul Davis, MD
Jed Holmes, MD
James Keller, MD
Angela Leiker, MD
Charlene Bui, PA-C
Mark Leiker, MD
David Netherton, MD
Darla Rivera, DO
Hai Truong, DO
Thanh Truong, DO

Medication History Authority / KSWebIZ Consent

To better serve your healthcare needs and requests, Primary Care Associates has implemented a new Electronic Medical Records (EMR) program. This will allow us to automatically import your medication history from third party sources (i.e. pharmacies). In order to transfer your current and past medications to the new system, we must have your authority.

The Kansas Immunization Registry, also referred to as KSWebIZ, is the statewide immunization registry. It is a web-based database that maintains complete, accurate, and secure immunization records for all Kansas residents.

The purpose of KSWebIZ is to consolidate immunization information among health care professionals, assure adequate immunization levels, and avoid unnecessary immunizations.

_____

Primary Pharmacy

_____

Address

By signing below, I hereby consent Primary Care Associates to transfer my Medication History and Immunization records.

_____

Print Name

_____

Patient Signature

_____

Date

Notice of Privacy Practice for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

Primary Care Associates, LLC is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record - you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the office/hospital;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.
- If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information has been disclosed or action has already been taken.
- If you want to exercise any of the above rights, please contact Primary Care Associates, LLC, in person or in writing, during regular, business hours. You will be informed of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Michelle Edwards, Compliance Manager at (316) 684-2851.

If you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Michelle Edwards, Compliance Manager. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Telephone: 202-619-0257
Toll Free: 1-877-696-6775

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Research*

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief*

We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations*

Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation*

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health*

- As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers*

Except in cases involving workers' compensation, disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions*

If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement*

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight*

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings*

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: 08/23/04

*If an item has an asterisk, you should consult state law to avoid conflicts. The American Health Lawyer's Association recommends checking the following state laws and regulations for preemption:

1. State licensing laws and regulations.
2. Mental health laws and regulations.
3. Substance abuse laws and regulations.
4. Electronic medical records laws and regulations.
5. Genetic testing laws and regulations.
6. HIV laws and regulations.
7. Pharmacy licensing laws and regulations.
8. Patient Bill of Rights.
9. General patient confidentiality laws and regulations.
10. State common law privacy protections.

Primary Care Associates

HEALTH HISTORY (Confidential)

Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (x) if your blood relative(s) had any of the following

Disease		Relationship to you
Mental Illness		
Asthma, Hay Fever		
Cancer		
Chemical Dependency		
Diabetes		
Heart Disease, Stroke		
AIDS		
Kidney Disease		
Tuberculosis		
Other_____		

HOSPITALIZATION / SURGERIES (other than pregnancy)

Mo/Yr	Hospital	Reason for Hospitalization

Have you ever had a blood transfusion? Yes No (Please Circle One)
If yes, please give approximate dates

SERIOUS ILLNESS/INJURIES	DATE	COMPLICATIONS

PERSONAL

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Sexual Practice: ☐ Active ☐ Inactive ☐ Same Sex ☐ Opposite Sex
☐ Multiple Partner ☐ Single Partner

PREGNANCY HISTORY

Date of last menstrual period_____

# of pregnancies_____ # of live births_____

# of miscarriages_____ # of stillborn_____

# of therapeutic abortions_____

# of multiple births (twins, etc.)_____

Mo/Yr. of birth	Mo/Yr. of miscarriage	(M) (F)

HEALTH HABITS Check (X) frequency of use

		Never	Occasionally	Frequently
	Caffeine			
	Tobacco			
	Alcohol			
	Tranquilizer			
	Sleeping Pills			
	Seatbelts			

OCCUPATIONAL CONCERNS

Check (x) if work exposed you to the following

	High Stress
	Hazardous Substances
	Heavy Lifting
	Others

Your Occupation (s):

Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐

Patient's Signature Date

Reviewed By Date

Patient's Name Date

Date of Birth

Primary Care Associates

HEALTH HISTORY (Confidential)

PLEASE CHECK (☑) BOXES THAT APPLY TO YOU

GENERAL

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Birth Defects
- ☐ Severe Allergies
- ☐ Severe Fatigue
- ☐ Night Sweats
- ☐ Poor Appetite
- ☐ Cancer of_____
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Other_____

MENTAL / EMOTIONAL

- ☐ High Stress
- ☐ Trouble Sleeping
- ☐ Eating / Dietary Problems
- ☐ Depression
- ☐ Suicide Attempts
- ☐ Severe Mood Swings
- ☐ Anxiety Attacks
- ☐ Sexual Problems
- ☐ Alcohol Problems
- ☐ Substance Abuse
- ☐ Domestic Violence
- ☐ Other_____

NEUROLOGICAL

- ☐ Epilepsy / Seizures
- ☐ Severe Headaches
- ☐ Loss of Memory
- ☐ Stroke
- ☐ Blackouts / Fainting
- ☐ Coordination Problems
- ☐ Numbness / Tingling
- ☐ Meningitis
- ☐ Brain Tumor
- ☐ Other_____

HEAD AND NECK

- ☐ Blindness
- ☐ Partial Vision Loss
- ☐ Color Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Severe Hearing Loss
- ☐ Severe Dizziness
- ☐ Loss of Smell / Taste
- ☐ Mouth Sores
- ☐ Lumps in Neck
- ☐ Other_____

CARDIOVASCULAR

- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Failure
- ☐ Chest Pain / Heartburn
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Blood Clots / Phlebitis
- ☐ Poor Circulation
- ☐ Abnormal Heart Rhythm

LUNGS

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Coughed Up Blood
- ☐ Pain with Breathing
- ☐ Other_____

INTESTINAL

- ☐ Stomach Ulcers
- ☐ Difficulty Swallowing
- ☐ Gallbladder Problems
- ☐ Liver Problems
- ☐ Colon Problems
- ☐ Blood in Stool
- ☐ Weight Loss
- ☐ Hepatitis
- ☐ Frequent Diarrhea
- ☐ Chronic Constipation
- ☐ Chronic Stomach Pain
- ☐ Other_____

BONE & JOINT

- ☐ Arthritis
- ☐ Gout
- ☐ Torn Cartilage
- ☐ Broken Bones
- ☐ Severe Neck Pain
- ☐ Severe Back Pain
- ☐ Osteoporosis
- ☐ Weakness (Arms / Legs)
- ☐ Joint Replacement
- ☐ Amputation
- ☐ Other_____

FEMALE ONLY

- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Vaginal Infection
- ☐ Frequent Vaginal Soreness
- ☐ Severe Pelvic Pain
- ☐ Pain with Intercourse
- ☐ Problems with Periods
- ☐ Infertility / Tubal Ligation
- ☐ Blood in Urine
- ☐ Frequent Urinary Infection
- ☐ Kidney Problems
- ☐ Abnormal Pap Smear
- ☐ Breast Problems
- ☐ Other_____

MALE ONLY

- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Discharge From Penis
- ☐ Sores on Penis
- ☐ Painful Testicles
- ☐ Problem with Erection
- ☐ Prostate Problems
- ☐ Blood in Urine
- ☐ Kidney Problems
- ☐ Infertility / Vasectomy
- ☐ Kidney Stones
- ☐ Other_____

SKIN

- ☐ Eczema
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Skin Cancer
- ☐ Hives / Rashes
- ☐ Severe Sunburn / Burn
- ☑ Use Sunscreen
- ☐ Moles Changed
- ☐ Hair Loss
- ☐ Other_____

INFECTIONS

- ☐ AIDS
- ☐ HIV Positive
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Polio
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Tropical Disease
- ☐ Fungal Infection
- ☐ Other_____

Please indicate
Mo. / Yr. of last: Pap _____ Mammogram_____ Cholesterol Check_____ Complete Physical_____

MEDICATIONS: List all medication you are currently taking. (Prescription & Non-prescription)		ALLERGIES: To medications or substances.
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	

Pharmacy Name:_____ Phone:_____

Your Name_____ Date of Birth_____ Today's date_____

Emergency Contact: Name_____ Phone Relationship

Primary Care Associates
7111 E. 21st St. North, Suite A
Wichita, KS 67206
Tel: 316-684-2851
Fax: 316-683-5239

Authorization To Use Or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

patient name | date of birth | Social Security Number

address (street, city, state, zip code) | telephone number

The following individual or organization is authorized to make the disclosure:

(FROM) Dr._____(first name)_____ (last name)_____

(address) (city) (state) (phone)

This information may be disclosed to and used by the following individual or organization:

(TO) Dr. (first name) (last name)

(address) (city) (state) (phone)

treatment dates: purpose of request:

The following information is to be disclosed: (Please check one box for each item.)

Yes	No		Yes	No	
☐	☐	physician notes	☐	☐	lab results
☐	☐	x-ray reports	☐	☐	MRI scans
☐	☐	cardiac studies	☐	☐	complete record
☐	☐	other_____			

If changing physicians, please indicate reason for change: (Please check one box)

___Moving	___Office Staff	___Medical Care
___Insurance Change	___Receptionist	___Availability
___Office Location	___Medical Assistant	___Financial
___Appointment Scheduling	___Nurse	___Other _____
___Time Spent in Waiting Room	___Provider	

sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

other rights:

(a) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

(b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.

expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event or condition, this authorization will expire in six months.)

signature of patient or legal representative date

if signed by legal representative, relationship to patient:

Primary Care Associates

Primary Care Associates
Medical Release Policy

It is the policy of Primary Care Associates to charge for requested copies of a consumer's medical records. A reasonable fee may include actual costs for copying, labor, mailing, shipping, or delivery.

Primary Care Associates may request that the fee be paid prior to release of the information for non-treatment or non-emergent purposes. Copies of records from other health care practitioners contained in Primary Care Associates records may also be made and given upon request. However, we cannot authenticate other providers' copies we have in our possession. A written release is required prior to releasing any records.

Primary Care Associates may charge the following:

1. Lawyers, court reporters
2. Insurance companies for reason other than payment purposes
3. Social Security Administration, SSI
4. Patients or their legally authorized representative for personal purposes such as copies to take to another provider, hospital, nursing home, home health agency or school, etc.
5. Records related to Workers Compensation cases according to the following fee schedule implemented by the State of Kansas Division of Workers Compensation effective December 1, 2001.

We will not charge a patient for their records when records are sent directly to another doctor, a VA office, a military facility or when the patient is leaving the country.

Charges for copies of records will be as follows:

Dictated Report $30 fee

Medical Records $18.97 fee

- No Charge for the pages between 1-10
- $.63 per page for the first 250 pages
- $.45 per page after first 250 pages