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)

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

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

7111 E 21st St N Suite A***Wichita, KS 67206
(316) 684-2851

DATE: ____/____/_____ **(Newborn to age 17)**

PEDIATRIC / ADOLESCENT HEALTH HISTORY FORM

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: _____/_____/_____ Age: _____ Current Grade:_____ School: _____

Gender: _____Male _____Female Birth Weight: _____ Pregnancy/Birth Complications?_____

MEDICAL HISTORY

Has your child ever had any of the following?

___ ADD/ADHD ___ Headaches/Migraines ___ Seasonal Allergies ___Anemia/Blood Disorder ___ Anxiety/Depression

___ Asthma ___ Diabetes ___ Seizures ___ Skin Conditions ___ Other Conditions (please specify) _____

Hospital Admissions/Surgeries _____

Year: _____ Illness or Operation: _____

Year: _____ Illness or Operation: _____

MEDICATION

Please list all medications your child is currently taking. Including over-the-counter medications, vitamins, & herbal remedies.

1. _____
2. _____
3. _____

MEDICATION & FOOD ALLERGIES

1. _____ **Reaction:** _____
2. _____ **Reaction:** _____
3. _____ **Reaction:** _____
4. _____ **Reaction:** _____

PRIOR TESTING (if applicable)

Last dental exam: _____ Last eye exam: _____ Last physical/Wellness exam: _____

Last lab work: _____ Normal: ___ Abnormal: ____ Who does your child live with? _____

SOCIAL HISTORY

Alcohol _____ Tobacco _____ Illegal Drug _____ Sexually Active? _____

FAMILY HISTORY

Current Health Problems or Cause of death

Mother Living? ___Yes ___No _____

Father Living? ___Yes ___No _____

Sisters or ___Yes ___No _____

Brothers Living? __Yes ___No _____

_____

Signature of person completing this form: _____

Date: _____/_____/_____

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