4940 B. W. 137th St. Leawood, KS 66224 505 S Hospital Dr Paola, KS 66071 421 S Maple Garnett, KS 66032 7820 W 165th St Overland Park, KS 66223

PATIENT INFORMATION - PLEASE PRINT!

How did you hear about us? ☐Internet Search ☐Social Media ☐Friend ☐Employer ☐Direct Mail Other__________

Name ____ SS# _______________ DOB _________________

Sex ☐M ☐F Address _________________________________ City ___________________ State _____ Zip __________

Phone# _____________________ Cell#_________________ E-mail____

Marital Status ☐S ☐M ☐D ☐W Other_________ **Patient's Employer** ____________ **Spouse's name** __________

Ethnicity ☐Hispanic/Latino Other____________ **Preferred Language** ☐English ☐Spanish Other_____________

Race ☐Caucasian ☐African American ☐Am Indian/Eskimo ☐Hispanic ☐Asian/Pacific Islander Other___________

Primary Care Physician ____

Is this injury work related or due to a motor vehicle accident? ( ) Yes ( ) No **Do you have an attorney?** ( ) Yes ( ) No

If Patient is under the age of 18, Please Complete this section:

Father's Name _____________________________________ Phone# _________________________________
Address ____
Mother's Name _____________________________________ Phone# _________________________________
Address ____
☐Pt lives with both parents ☐Lives with mother ☐Lives with Father Other ___________________
Policy Holder of Insurance _____________________ DOB ________ Relationship: __________________

Please choose one of the following options:

___ If I choose not to accompany my minor child or dependent to his/her follow-up appointments, I authorize Mid-America Orthopedics to perform the treatments and/or procedures necessary to deliver appropriate healthcare as previously discussed with one or both of the patient's parents listed above. **I understand my presence may be required at some appointments at the discretion of the healthcare provider.**

___ I will accompany my minor child or dependent to his/her follow-up appointments. I understand if I do not accompany him/her, he/she will not be seen.

HIPAA Authorization/ Emergency Contact

I authorize Mid-America Orthopedics KC, LLC to discuss or release my protected healthcare information to the following individuals:

Primary Name ______________________________ Relationship _______________________ Phone Number ___________

Secondary Name _____________________________ Relationship________________________ Phone Number ___________

______ A. I understand this authorization is voluntary and I may refuse to sign.

______ B. I understand that my refusal to sign will not affect my ability to obtain treatment.

______ C. I understand that I may revoke this authorization at any time by notifying Mid-America Orthopedics KC, LLC in writing of my intent to revoke this authorization, except to the extent that action has been taken in reliance on this authorization.

______ D. 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 will be protected by federal privacy laws.

ASSIGNMENT AND RELEASE

Release of Medical Information, I hereby authorize Mid-America Orthopedics KC LLC and all other healthcare providers that are administering care here to release my medical information and/or statement of charges in connection with these services to, but not limited to, an insurance carrier, workman's compensation carrier, health and welfare funds or to attorneys, consultants, and anyone assisting in obtaining payment.

Insurance Assignment. I hereby assign medical benefits of any whatsoever arising out of any policy of insurance, insuring the patient or any other party liable for the patient's care, to Mid-America Orthopedics KC, LLC to be applied to the charges for services rendered.

Agreement to Pay for Services. I agree to pay Mid-America Orthopedics KC, LLC for charges for services rendered to or on behalf of the patient, including amounts for insurance deductibles and co-insurance which are not covered by the patient's insurance carrier or workers compensation. I also agree to pay any fees charged by attorneys, consultants and anyone else who assist in the collection of private pay amounts due.

SIGNED: ____ DATE: ____________________________