

Tallgrass Immediate Care & Family Medicine
601 SW Corporate View Road, Suite 200
Topeka, KS 66615

Paper Out: _____

Paper In: _____

DATE _____

PATIENT LEGAL NAME _____
Last Name First Name Middle

ADDRESS _____
Street City State ZIP

Home Phone

Cell Phone

SEX M F **MARITAL STATUS** S M W D **DATE OF BIRTH** _____ **SSN** _____

RACE _____ **ETHNICITY** _____ **PREFERRED LANGUAGE** English Spanish

HOME # _____ **CELL #** _____ **WORK #** _____

EMAIL ADDRESS _____ **EMPLOYER** _____

Emergency contact or name of person I give permission to discuss my health care:

NAME _____ **RELATIONSHIP** _____ **PHONE** _____

RESPONSIBLE PARTY _____ **RELATIONSHIP TO PATIENT** _____

PHONE NUMBER _____ **SSN** _____ **DOB** _____

ADDRESS (if different from patient) _____

PRIMARY INSURANCE TYPE _____ **NAME OF POLICY HOLDER** _____

RELATIONSHIP TO PATIENT _____ **DOB** _____ **SSN** _____

ADDRESS (if different from patient) _____

SECONDARY INSURANCE TYPE _____ **NAME OF POLICY HOLDER** _____

RELATIONSHIP TO PATIENT _____ **DOB** _____ **SSN** _____

ADDRESS (if different from patient) _____

INSURANCE AUTHORIZATION AND CONSENT FOR TREATMENT

I request that payment of authorized Medicare/other insurance company benefits be made either to me or in my behalf to Tallgrass Immediate Care. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or Intermediaries or carriers of any information needed for this or a related Medicare claim/other insurance company claim, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize Tallgrass Immediate Care to administer diagnostic and medical procedures as may be necessary for proper health care and to release my medical records to my referring physician and/or specialty physician as deemed necessary. I understand that my insurance may not cover all of my incurred charges and I accept full financial responsibility for any remaining balance. I further understand a collection fee of 33% will be added to my account in the event that the balance is not paid when due and as such, turned over to collections.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Your health information is important to you and also important to this office. Your health information is recorded in many ways. All of this information is subject to protection to certain state and federal laws from inappropriate release of others. The privacy practices that we follow to protect your health information are contained in our "Notice of Privacy Practices." The "Notice of Privacy Practices" explains in detail how medical information about you may be used and disclosed and how you can obtain access to this information. It also explains your health information rights and the responsibilities of this office when it comes to your health information. We are required to provide to you a copy of our "Notice of Privacy Practices" and obtain your signature stating that you have been offered a copy of the "Notice of Privacy Practices." By signing below I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Patient's Signature

Date Signed

Parent/Guardian Signature

Date Signed

Please make sure you fill out everything in bold/italics. Thank you!

Family Medicine at Tallgrass

Dr. Betsy Johns, Dr. Karen Bruce, Dawn Magee ARNP, Heather Myers ARNP, Bobbe Mansfield ARNP

Authorization for Release of Healthcare Information

Patient Name _____

Address _____

Date of Birth _____

I hereby authorize the transfer of the following healthcare information

To:	Family Medicine at Tallgrass	From:	_____
	601 SW Corporate View Rd Ste 200		_____
	Topeka, KS 66615		_____
	Phone: (785) 295-4500, (785) 234-0880		_____
	Fax: (785) 271-2220, (785) 234-4150		_____

Entire Contents of Chart

OR

Progress Notes

Pathology Reports

Lab Reports

Correspondence

Operative Reports

Psychotherapy Notes

Purpose of Disclosure:

Continuing Patient Care

Other: _____

I understand that specific information to be released may include, but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand this authorization is subject to revocation. Withdrawal by me at any time in writing to the custodian of medical records in your office, except to the extent the action has already been taken to release this information to Family Medicine at Tallgrass. This authorization shall remain valid unless revoked but will expire in one year after signing. I have the right to inspect a copy of the health information to be released, and if I do not sign this authorization, your office will not release my health information to Family Medicine at Tallgrass. Notice is given to Family Medicine at Tallgrass that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

Signature of Patient

Date

Signature of Parent of Guardian

Date

Signature of Witness

Date

Relationship to Patient

Date