Patient Demographics

Patient Name _____ Maiden Name _____

Date of Birth _____ Social Security Number_____

Address _____

City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____

Email Address _____

Pharmacy _____ City/Cross Streets _____

Employer Name_____ Work Phone _____

Responsible Party (if other than patient) _____ Relationship _____
Primary Care Physician _____ Phone Number: _____
Referred By _____ Phone Number: _____

Marital Status Single Married Legally Separated Divorced Other

Insurance Information

Primary Insurance Company _____ I have no insurance
Subscribers Name (if other than patient) _____D.O.B._____
Subscribers Address_____
Relationship to Subscriber Self Spouse Parent Other
Subscribers Social Security Number _____

Secondary Insurance Company _____
Subscribers Name (if other than patient) _____D.O.B._____
Subscribers
Address_____
Relationship to Subscriber Self Spouse Parent Other
Subscribers Social Security Number _____

Financial Consent

I authorize release of my medical records as required by my insurance company(s) necessary to process my claims for charges incurred at Kansas City ObGyn. I hereby authorize payment directly to Kansas City Ob Gyn P.A., of any insurance coverage for office procedures or hospital charges.
I understand that I am fully responsible for all charges not covered by my insurance company, included but not limited to medical services deemed routine, elective or not medically necessary and/or any co-pays, deductibles, coinsurance or non-covered items specified by my insurance company.
I also understand that doctor and office fees are due and payable when services are rendered.
I, the undersigned, authorize treatment by the doctor in this office.

Signature _____ **Date**_____
(If patient is a minor, parent or guardian signature required)

Kansas City Ob Gyn

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At Kansas City Ob Gyn, we have implemented Meaningful Use initiatives that are part of the HITECH provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, also known as the Stimulus Plan.

As a result, we are now required to collect government-requested data including information regarding the primary language, race and ethnicity of our patients. The purpose of Meaningful Use is to ultimately improve patient care and lower health care costs and we aim to fully comply with the initiative.

The information you provide will be used for reporting purposes only.

Please Answer the Following Questions:

Your name: _____ Date of Birth:_____

Race: White Black or African American Asian American Indian or Alaska Native Native Hawaiian or other Pacific Islander Declined

Ethnicity: Hispanic or Latino NOT Hispanic or Latino Declined

Preferred Language: English Spanish Indian Japanese Chinese Korean French German Russian Other

E-mail Address (please provide):

_____

Thank you for your participation

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Office Policy

We would like to thank you for choosing Kansas City ObGyn as your medical provider. We are committed to providing you with the best possible care and service. We would like to make your aware of our office policies and request that you read and sign this document prior to receiving medical treatment.

Assignment of Insurance Benefits

- I hereby authorize and assign, my insurance carrier(s), to make payment directly to Kansas City Ob Gyn, of insurance benefits for services herein specified and otherwise payable to the insured. KCOBGYN files both primary and secondary insurance as a courtesy to patients. I understand and agree that I am financially responsible to KCOBGYN for all charges incurred regardless of potential insurance benefits, including but not limited to Co-Payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand KCOBGYN will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

Insurance Card and Driver's License

- I understand driver's license and insurance cards must be presented at time of service, or I will be self pay until insurance cards are presented. If insurance changes within treatment, cards must be presented within 30 days so KCOBGYN can timely file claims to new insurance. Co-Payments, Co-Insurance, Deductibles and Non–covered services are due at the time of service. I understand my insurance company may require a referral before being seen. If not obtained, I will be responsible for incurred charges until a referral is obtained. If it's determined that your insurance was not active at the time of service, your card will be charged automatically for the self-pay amount of the visit upon receiving a claim denial.

Payment of Estimated Cost (Global Maternity, Surgery or Office Procedures)

- I understand that I am financially responsible for all charges arising for treatment by KCOBGYN. I understand that if I am seen as an Ob patient, I will be provided an estimate for my care including delivery, at the beginning of my pregnancy. The estimated out of pocket cost will be required to be paid by 28 weeks of my pregnancy. Once all claims have been processed and paid by my insurance company, KCOBGYN will issue a refund to me in the same form of payment, if applicable. I understand that the estimated out of pocket cost for all procedures and ultrasounds are due at the time of service and that out of pocket costs for surgeries are due one week prior to the surgery date. If paid by credit card and the refund cannot be made back to the credit card, a 3% fee will apply to process a check refund.

No Show and Late Cancellation

- I understand KCOBGYN will charge my card on file for $30 if I do not show up to an appointment or if I cancel less than 24 hours prior to the appointment time. I understand this charge is not covered by my insurance policy. If I arrive late for an appointment I may be asked to see another provider or reschedule. Appointment reminders and office communication are sent by e-mail, phone or text but it is ultimately it is patient responsibility to remember appointment .

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Returned Check Fee

- I understand if KCOBGYN receives a returned check, I will be charged an additional $35 above the amount on the check and I will be on a cash only basis thereafter.

Noncompliance

- I understand KCOBGYN has the right to discharge any patient from this practice at any time due to non-compliance. If this occurs, records will be released to a physician of my choice only when a signed release of information is received in this office.

Collections

- I understand that if my bill is not paid on time, that I may be turned to a collection agency. I understand that they may contact me via all phone numbers or email provided to the practice. All balances with the collection agency must be paid in full before having any future treatments with KCOBGYN. I also understand that there will be a $40 reinstatement fee that must be paid prior to scheduling an appointment. The full self-pay amount of the visit will be due at each future appointment as a guarantee of payment. KCOBGYN will submit my claim to my insurance company and I will be reimbursed once my claim is processed.

FMLA

- I understand that FMLA will take two weeks to process from the date provided to the office. I also understand there will be a $15 charge for all FMLA paperwork to be completed. A secondary set of forms for patient or spouse will be an additional $10 per set.

Phone Calls

- I understand that phone calls will be returned throughout the day, when the Nurses are able to complete calls. I also understand that any call received after 3 pm will be returned the following business day, unless in an emergency situation.

Prescriptions

- I understand that prescription refills need to go through the pharmacy. Please allow 24 hours for any prescription refill, Monday – Thursday. Any prescriptions received on Fridays will not be filled until the following Monday. I understand that most prescriptions will be sent electronically to the pharmacy that I have selected and I am responsible for informing the office of any pharmacy changes needed.

I have read and understand the policies outlined above and agree to accept responsibility as described.

Patient name: _____

Guardian Name if Patient under 18: _____ Date: _____

Signature: _____Date of Birth: _____

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How would you like to receive appointment reminders:

☐ Text ☐ Phone Call: Please select **home / cell** phone

***Email reminders will automatically be sent**

EMERGENCY CONTACT

DO NOT LIST SELF

Name_____ Relationship _____Phone _____

HIPAA/RELEASE OF MEDICAL INFORMATION

In order to protect your confidentiality and to comply with government regulations (HIPAA), Kansas City Ob Gyn P.A. is required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

The physician and staff at Kansas City Ob Gyn may discuss my medical information and/or care with the following. **(Please check all that apply and list names.)**

☐ My Spouse _____Phone_____

☐ Name_____ Relationship_____Phone_____

MESSAGES:

I give my consent to the physicians and staff of Kansas City Ob Gyn to leave or discuss treatment, surgery, lab, radiology results or other information regarding my care as follows. **(Please check all that apply message options that apply OR mark if you do NOT consent)**

☐ On voice mail on cell phone.
☐ On answering machine or voice mail at home.
☐ On answering machine or voice mail at work.
☐ Sent via email provided.

☐ **I do not consent to messages being left at home, work, or with any other person.**

Notice of Privacy Practices: I acknowledge that I have read and understand the content of the Notice of Privacy Practices (HIPAA).

_____ **D.O.B.**_____

Print Patient's Name

X_____ _____

Signature (Patient, Parent or Guardian) **Date**

Kansas City Ob Gyn

RID # _____

RID # _____

Acct # _____

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UPDATED Office Credit/Debit Card Policy

Kansas City Ob Gyn requires a Credit/Debit Card to be kept on file for all services. If there is a patient balance after the insurance claim has processed, we will send a statement for balances greater than $20. If the statement balance is unpaid 30 days after your statement date, the card on file will be charged the outstanding balance due. We will not call before the card is processed. All balances $20 and under will be charged to the card on file the day that insurance processes the claim. I understand that I am responsible for a $25 charge each time credit/debit card declines and that I am responsible for providing an updated card if it expires or is compromised.

I understand and agree that I am financially responsible to Kansas City Ob Gyn for all charges incurred regardless of potential insurance benefits. I understand it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

I understand that insurance cards must be presented at time of service, or I will be considered self-pay. If insurance changes, KCOB must be notified within 30 days so claims can be filed to new insurance timely. If my claim is denied for inactive insurance, I agree that my card will be charged for the self-pay amount and a statement will not be sent.

I understand that if I decline to provide a credit/debit card on file, I will be required to put a deposit on file for my service. A refund will be issued to the credit card once the claim has been processed by insurance.

VISA and Mastercard have implemented a new requirement for verifying your account. Upon entering your account number into the secured system, they may run a $0 charge on your account.

Patient Printed Name: _____ ***Date:*** _____

Patient Signature: _____

Cardholder Name: _____

Cardholder Address: _____

City/State/Zip: _____

Card Type: (please circle) VISA/MASTERCARD/AMEX/DIS (please check) ☐ **HSA** ☐ **FSA**

EXP. DATE _____

Credit Card Number: _____-_____-_____-_____ **CVV/CVC** _____

Cardholder Signature: _____ ***Office Staff:*** _____

****If the first card on file is an HSA or FSA we do require a second card.**

Card Type: (please circle) VISA/MASTERCARD/AMEX/DIS (please check) ☐ **HSA** ☐ **FSA**

EXP. DATE _____

Credit Card Number: _____-_____-_____-_____ **CVV/CVC** _____

Cardholder Signature: _____ ***Office Staff:*** _____

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KANSAS CITY OBGYN NO SHOW POLICY

I _____ understand that if I don't give Kansas City OBGYN a 24 hour notice before cancelling or no showing any of the following appointments I will be charged the amount correlating with the specific appointment. If I have multiple appointments, I will be charged for EACH individual appointment. I am fully aware that the credit/debit/HSA card I have left on file will be charged immediately once the appointment has been missed without warning.

Office Visit: $30.00
Sonogram: $50.00
Procedure: $100.00

Patient Name (Printed)_____
Date of Birth_____

_____
Signature of Patient or Guardian

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