

Colon & Rectal Surgeons of Kansas City

Please print. Please do not leave any blanks.

Have you ever been seen by a physician in this practice? YES NO Who? _____

If so, when and why? _____

PATIENT (full name): _____
(First) (Middle) (Last)

DOB: _____ AGE: _____ SEX: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ SINGLE MARRIED DIVORCED WIDOWED OTHER _____

PRIMARY PHONE: (____) _____ CIRCLE ONE: HOME CELL WORK

SECONDARY PHONE: (____) _____ CIRCLE ONE: HOME CELL WORK

EMPLOYED RETIRED BY: _____

OCCUPATION: _____ PHONE: (____) _____

ADDRESS: _____ EMAIL: _____

EMERGENCY CONTACT: _____ RELATION: _____

PRIMARY PHONE: (____) _____ SECONDARY PHONE: (____) _____

PRIMARY/REFERRING PHYSICIAN: _____ PHONE: (____) _____

CARDIOLOGIST (if applicable): _____ PHONE: (____) _____

PRIMARY INS: _____

GROUP #: _____

ID#: _____

POLICY HOLDER: _____

RELATION: _____

DOB: _____

SSN: _____

EMPLOYER: _____

WORK PHONE: (____) _____

SECONDARY INS: _____

GROUP #: _____

ID#: _____

POLICY HOLDER: _____

RELATION: _____

DOB: _____

SSN: _____

EMPLOYER: _____

WORK PHONE: (____) _____

PHARMACY PREFERENCE: _____ PHONE: (____) _____

PRESCRIPTION INSURANCE ID#: _____

LAB PREFERENCE: _____ PHONE: (____) _____

PATIENT SIGNATURE: _____ DATE: _____

Colon & Rectal Surgeons of Kansas City

Colon & Rectal Surgeons of Kansas City has adopted a policy requiring their staff to obtain authorization from the patient to leave detailed messages if the patient is unavailable. This policy is to protect the privacy of the patient and also prohibit the staff of Colon & Rectal Surgeons of Kansas City from violating the patient's confidentiality. If there is not a signed consent on file, we will leave a message only stating our name and phone number. This message could be left on an answering machine, voicemail, or with a person answering the phone number a patient has provided.

By completing the consent form below, you are allowing the staff of Colon & Rectal Surgeons of Kansas City to leave a detailed message on an answering machine, voicemail, or with a specified individual. By signing the form you are also consenting to the mailing/faxing of any medical records requested by you, or any other physician participating in your care.

I give my consent to the staff of Colon & Rectal Surgeons of Kansas City, P.A. to leave a message regarding treatment, test results, billing, or any other information necessary.

Voicemail at home.

Voicemail on a cell phone.

Voicemail at work.

With: _____ Relationship: _____

With: _____ Relationship: _____

I do not want messages left at home, work, or with any other person other than myself.

I give my consent to discuss clinical and medical details of my condition including (but not limited to): lab/test results, scheduling and other necessary information as necessary by the physician and/or staff of Colon & Rectal Surgeons of Kansas.

May discuss with: _____

Relationship: _____

Name (Print): _____

Patient Signature: _____

Date: _____ Witness: _____

(Without a witness signature, this is an invalid document.)

COLON & RECTAL SURGEONS OF KANSAS CITY

All office co-pays are due at the time of service. Knowledge of insurance co-pays, co-ins, and deductibles is the responsibility of the person using the medical insurance. If your insurance requires a referral, it is the patient's responsibility to know and obtain this before coming in for an office visit and/or surgery. If you are unsure, you should contact your PCP or your insurance company directly. If you have Medicare or a supplemental insurance, we will not be collecting co-pay at the time of service. We file insurance claims **ONLY** for the companies we are contracted with. It is the patient's responsibility to know what physicians your insurance company participates with. This office does not participate with Kansas or Missouri Medicaid/First Guard. Our office staff will not be able to answer detailed questions regarding your personal policy as each person's is different. If we are not contracted with your insurance company, or if you are a private pay patient, all charges for examination, consultation and special procedures performed in the office are **due and payable in full at the time services are rendered**. Please discuss other necessary arrangements with our office manager **BEFORE** you see the doctor. We can provide you with an itemized receipt of your charges or payments. This can be used for any insurance claims you want to process. Please be sure to request this receipt before you leave. We do file all surgery claims.

Payment of the doctor's fee is the personal financial obligation of the patient or the person authorizing treatment. This personal obligation is not altered because the patient's charge is covered in part or in whole, by insurance. **It is your responsibility to know what is and is not covered by your insurance company.** Full payment is expected within 30 days after your response from your insurance company. Any statement not receiving payment every 30 days is past due. Regardless of performance by your insurance company, you are responsible for payment of your account. In the event that you should default, you will be responsible to pay all reasonable collection costs including but not limited to attorney fees, court costs, and the like.

We are happy to complete disability and FMLA forms for you, however, there is a fee of **\$35.00 for each set** of forms completed. This fee must be made prior to the completion of the forms. We will only complete the physician section. You may fax the forms to (913)677-1164, or mail them to our office. Address: 8901 W. 74th St. #149, Shawnee Mission, Ks. 66204. One of our staff will inform you when the forms are complete.

- Signature _____ Date _____

Authorization to Release Information and Pay Benefits to Physician

I hereby authorize the release of any medical or other information necessary to process my claims. I also authorize payment of medical benefits directly to Bruce D. Graham, M.D.P.A. d/b/a Colon & Rectal Surgeons of Kansas City for the services described on the attached claim form. (This applies to all patients of this practice regardless of which physician they are seeing.)

- Signature _____ Date _____

Medicare Consent to Agreement

I request that payment of authorized insurance benefits be made in my behalf to Dr. Bruce D. Graham for any services. I authorize any holder of my medical information, to release to the Centers for Medicare and Medicaid Services and its agents, any information needed to determine benefits payable for related services. I authorize my insurance to furnish the above named doctor any information regarding my claims under Title VII of the Social Security Act. I agree that a photographic copy of this authorization is as valid as the original.

- Signature _____ Date _____

Notice of Privacy Practice

I have received a copy of Bruce D. Graham, M.D.P.A. d/b/a Colon & Rectal Surgeons of Kansas City Notice of Privacy Practices for Protected Health Information with an effective date of April 14, 2003.

- Signature _____ Date _____

Patient History

Name: _____	Gender: M F	Age: _____	Date: _____
Chief complaint: (Why are you here?) _____			
Symptoms: (Circle all that apply.)			
diarrhea	constipation	incontinence(loss of bowel control)	bloating
nausea	vomiting	abdominal pain	anal pain
itching	burning	swelling around the anus	rectal bleeding
prolapse (tissue coming out the anus)		other: _____	
Current Medications: _____			

Do you take: daily aspirin? yes no plavix? yes no coumadin? yes no

Drug Allergies: _____

Medical History: (Check all that apply.)

Heart disease	High blood pressure	Stroke
Angina (chest pain)	Heart attack	High Cholesterol
Heart murmur	Heart Surgery (Year? _____)	Defibrillator or Pacemaker
Lung Disease	Asthma	Tobacco use
Diabetes (Type I or II? ___)	Low Thyroid	Cancer (What kind? _____)
Chrohn's Disease	Ulcerative Colitis	Irritable Bowel Syndrome
Colon Polyps	Other: _____	Other: _____

Has anyone in your family been diagnosed with:

Diagnosis:	Relationship to you:	Age at diagnosis:
Breast cancer?		
Ovarian cancer?		
Uterine cancer?		
Thyroid cancer?		
Colon/Rectal cancer?		
Ulcerative colitis?		
Crohn's disease?		
Polyps?		
FAP?		
Other?		

Surgical Procedure:

Procedure	Physician	Date
Colonoscopy		
Colon Surgery		
Anal/Rectal Surgery		
Artificial Joints		
Heart Valves		
Hysterectomy		
Obstetric: #pregnancies	# vaginal deliveries	#c-sections
History of Episiotomy or tear:		