



Patient Registration Form

Last Name: _____ First Name: _____ MI: _____
Birth date: ____/____/____ SSN: _____ Gender (please circle): Male Female
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Employer Name: _____ Employer Phone: _____ - _____ - _____
Address: _____ City: _____ St: _____ Zip: _____
Reason for today's visit: _____
How did you hear about us? _____ E-Mail Address: _____
Primary Physician's Name: _____ Preferred Pharmacy: _____

***Primary Insurance: _____ Co-Pay: _____
Insured Name: _____ Relationship to Patient: _____
Address of Insured: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Birth date of Insured: ____/____/____ SSN: _____ Gender (please circle): Male Female

***Secondary Insurance: _____ Co-Pay: _____
Insured Name: _____ Relationship to Patient: _____
Address of Insured: _____ City: _____ St: _____ Zip: _____
Birth date of Insured: ____/____/____ SSN: _____ Gender (please circle): Male Female
Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
Employer Name: _____ Employer Phone: _____ - _____ - _____

PLEASE COMPLETE THIS SECTION IF PATIENT IS UNDER 18

Guarantor Name: _____ Relationship to patient: _____
Birth date: ____/____/____ SSN: _____ - _____ - _____
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

PREFERRED LAB

Due to recent changes in insurance companies' policies, Sunflower Prompt Care now requires that you list your preferred lab. This will help ensure that we send your specimens to the lab company your insurance prefers. (i.e. Stormont Vail, Lab Corp, St. Francis, or Quest). If you do not have a preference, write no preference.
Preferred Lab _____
Patient/ Gaurdian Signature _____

MAKE SURE TO SIGN AND DATE BELOW

Emergency contact: _____ Phone# _____ Relationship: _____
Patient or Guardian Signature: _____ Date: ____/____/____



FINANCIAL POLICY

Patient Name: _____ Date of Birth: ____/____/____

PAYMENT POLICY: Patients with insurance your *co-payments are due the day of service*. If you do not pay your co-payment the day of service it is subject to a 5% collection fee.

PATIENTS WITH INSURANCE: We bill most primary and secondary insurance carriers for you if presented with your valid insurance card at the time of service.

*******Your agreement with your insurance carrier is private; we do not regularly investigate why a carrier has not paid or why payment was less than anticipated. If an insurance carrier has not paid within 60 days from submission, you are responsible for full payment.*******

MEDICARE PATIENTS: We will bill Medicare and secondary insurance carriers for you if you present a valid insurance card at the time of service.

NON-COVERED SERVICES: Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

YEARLY HEALTH CHECKS: *Preventive care checks may or may not be covered* under your health insurance policy, even though your physician may require them. **You can call your insurance company for verification.**

****WORKER'S COMPENSATION ONLY:** In order to bill the worker's compensation insurance company, we will need the contact person's information, case number and carrier name **prior to your visits.**

Worker's Comp. Contact Information:

Company: _____

Name of Contact: _____ Phone: _____

_____(Initials) I have read, understood, and agreed to the above financial policy for payment of professional fees.

****Contact Instructions****

I hereby authorize Sunflower Prompt Care and designees to discuss my care and treatment, arrangements for my care and treatment, or payment for my care and treatment with individuals who are involved with my care. These individuals are:

Name	Phone Number

Permission is effective for a period of:

- 90 days
- Indefinitely
- Other _____

I understand that I can modify this list at any time.

Sunflower Prompt Care will make reasonable efforts to comply with this request, in the best interest of the patient. This form will supersede all prior requests.

Patient Signature _____ **Date** _____

(If Durable Power of Attorney for Health Care – legal documentation of such must be available)



Patient Name: _____ D.O.B.: ____/____/____

Gender: Male ___ Female ___ Medication Allergies: _____

Health History

This form is confidential and will be put directly in your medical chart. Please complete to follow information to best of your ability. Your answers will help the health care provider understand your medical concerns and conditions.

PERSONAL MEDICAL HISTORY: please indicate whether you have had any of the follow medical problems (with dates).

___ heart disease ___ high blood pressure ___ high cholesterol
Specify type _____ ___ diabetes ___ thyroid problems
 ___ asthma/lung disease ___ kidney disease ___ cancer: (*specify*) _____

Other: (*specify*): _____

In the past month, have you had little interest in pleasure in doing things, or felt down, depressed or hopeless? ___ Yes ___ No

FAMILY MEDICAL HISTORY: please indicate whether anyone in your immediate family has any of the follow medical problems (with dates)

___ heart disease ___ high blood pressure ___ high cholesterol
Specify type _____ ___ diabetes ___ thyroid problems
 ___ asthma/lung disease ___ kidney disease
 ___ cancer: (*specify*) _____

SURGICAL HISTORY: Please list all prior surgeries

IMMUNIZATIONS Current Yes ___ No ___ Last tetanus _____

SOCIAL HISTORY

Tobacco Use

Cigarettes ___ never ___ quit date _____
 ___ current smoker: packs/day _____ # of yrs _____
 Other Tobacco ___ pipe ___ cigar ___ snuff ___ chew
 Are you interesting in quitting? ___yes ___no

Alcohol Use

Do you drink alcohol? ___yes ___no
 # of drinks/week _____

Drug Use

Do you use any recreational drugs? ___yes ___no
 Have you ever used injectable recreational drugs? ___yes ___no

Women's Health History

LMP ___ #pregnancies ___ #deliveries ___ #abortions ___ #miscarriages ___
 Age at start of periods: _____ Age at end of periods (if applicable) _____
 Last Mammogram _____ Last PAP _____ **ARE YOU PREGNANT?** ___Yes ___No

MEDICATIONS: Prescription and non prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Date started	Name of medication	What's it for	Date stopped or changed

Date: ____/____/____



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785-246-3733

Authorization for Use or Disclosure of Health Information

This authorization for use or disclosure of health information is required by state and federal law. Kansas law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the State of Kansas.

I, _____ hereby authorize Sunflower Prompt Care
(Name of patient)

to use or disclose to me or specific health information through telephone reminders and/or messages when specific tests or appointments have been recommended. This information may include; information regarding medications, referral appointments, follow up appointments, labs, ultrasound, x-rays, and immunization records, etc.

I may refuse to sign this authorization, and my refusal will not affect my ability to obtain treatment. I may revoke this authorization at any time in writing. The revocation must be signed by me or on my behalf and sent to the address on the top of this form. The revocation is effective upon receipt but will have no impact on uses or disclosure made while the authorization was valid.

I have a right to a copy of this authorization.

This authorization shall be valid until revocation by patient or guardian.

Patient/Patient Guardian Signature: _____ **Date:** __/__/____

Preferred telephone number: (____) _____ - _____



Notice of Privacy for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully!

Sunflower Prompt Care is permitted by federal privacy law as to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Health Information for Treatment Purposes are:

- A nurse obtains treatment information and records it in a health record.
During the course of treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Examples of Use of Health Information for Payment Purpose:

- We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Examples of Use of Your Information for Health Care Options:

- We obtain services from our insurers or other business associates such as quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

The health and billing records we maintain are the physical property of Sunflower Prompt Care. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital—we are not required to grant the request, but we will comply with any request granted;
Obtain a paper copy of the current Notice of Privacy for Protected Health Information ("Notice") by making a request at our office/hospital;
Request that you be allowed to inspect and copy your health record and billing records-you may exercise this right by delivering a request to our amendment;
Appeal a denial of access to you protected health information, except in certain circumstances;
Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. However Sunflower Prompt Care may deny your request if you have asked to amend information that:
- Was not created by Sunflower Prompt Care or if the person/entity who created the information is no longer available to make the amendment.
- Is not part of the health information kept by Sunflower Prompt Care;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request writing to Sunflower Prompt Care.
Obtain an accounting of disclosures of your health information is required to be maintained by law. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at you request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition or your death.

Additional Use of Health Information:

Sunflower Prompt Care has my consent to contact my primary care provider _____ regarding medical care provided by Sunflower Prompt Care. Initial Here: _____

I acknowledge that I have read this Privacy Notice and understand its contents. I also acknowledge that I have been offered a copy.

Signature of Patient/Parent or Guardian _____ Date _____