10777 Nall Ave Ste. 300, Overland Park, KS 66211
17067 S Outer Rd. Ste. 301, Belton, MO 64012
P: 913.642.0200 f: 913.563.6699
www.apexorthokc.com

## PATIENT INFORMATION

Name______________________________________________ Preferred Name/Nickname__________________________

Date of Birth _____/_____/_______ Age _________ Marital Status ◯ Single ◯ Married ◯ Other

Address________________________________[Apt ______] City________________________ State_______ Zip_________

Primary Contact Phone ______________________________ ◯ Home ◯ Cell ◯ Work

Secondary Contact_________________________________ ◯ Home ◯ Cell ◯ Work

Other Contact_____________________________________ ◯ Home ◯ Cell ◯ Work

E-mail ____________________________________________ COS may send me secure email/text messages ◯ Yes ◯ No

◯ Male ◯ Female SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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Preferred Language ◯ English ◯ Other ____________________________________________________________

Race ◯ American Indian/ Alaska Native ◯ Black or African American ◯ Asian

◯ Native Hawaiian/ Other Pacific Islander ◯ White

Ethnicity ◯ Hispanic/ Latino ◯ Not Hispanic/ Latino ◯ Other__________________________

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Primary Care Doctor____________________________________ Number (_____)________-____________________

Preferred Pharmacy_____________________________________ Number (_____)________-____________________

Address________________________________________ City____________________________ State_________

## HIPAA & EMERGENCY CONTACTS/ RELEASE OF MEDICAL & APPOINTMENT INFORMATION

Name________________________________________________ Number (______)________-______________________

Relationship________________________________

Permission to share ◯ All info ◯ Emergency Only ◯ Discuss Appointment ◯ Medical Information

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Name________________________________________________ Number (______)________-______________________

Relationship________________________________

Permission to share ◯ All info ◯ Emergency Only ◯ Discuss Appointment ◯ Medical Information

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________________, have received a copy of Signature Medical Group of KC, P.A.'s updated Notice of Privacy Practices.

Signature_______________________________________________ Relationship to the patient______________________

Patient or Parent/ legal guardian/ legally responsible person Date_________________________

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For office use only : We attempted to obtain writen acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ◯ Individual/ representative refused to sign the form ___________________

◯ An emergency situation prevented us from obtaining acknoweledgement________________

APEX ORTHOPEDICS & SPORTS MEDICINE

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Name ______________________ Date of Birth ______________________

Referral Source:

○ ER/ Urgent Care ______________ ○ Referring MD/NP/PA ______________

○ Physical Therapy/ Trainer ______________ ○ Work Comp/ Attorney/ Legal ______________

○ Patient/ family/ friend ______________ ○ Employee ______________

○ Website/ Facebook ○ Insurance ○ Other ______________

Employment/ Student Information

Occupation ______________ Employer ______________ ○ Student ○ Full-time ○ Part-time

Responsible Party/ Guarantor: ○ Self

○ Other: Name ______________ Number (____) ____ - ________

Address ______________

Email ______________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Relationship ______________ Date of Birth ____/____/________

○ Child (Under 18): Name of Father, Mother, or Guardian ______________

## INSURANCE INFORMATION

Policy Holder: ○ Self ○ Guarantor ○ Spouse ○ Other ______________

Primary Insurance Company ______________

Policy ID Number ______________ Group ID Number ______________

Policy Holder's Information [If not Self or Guarantor] Name ______________

Date of Birth ____/____/________

Address ______________ City ______________ State ______ Zip ______

Number (____) ____ - ________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ○ Male ○ Female

Secondary Insurance Company ______________

Policy ID Number ______________ Group ID Number ______________

Policy Holder's Information [If not Self or Guarantor] Name ______________

Date of Birth ____/____/________ Relationship ○ Self ○ Spouse ○ Child ○ Other

Address ______________ City ______________ State ______ Zip ______

Number (____) ____ - ________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ○ Male ○ Female

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Name_______________________________________________Date of Birth_____________________________________

## CONSENT TO TREAT

I hereby consent to the administration and performance of all treatments, performance of procedures as my be deemed necessary or advisable, performance of diagnostic procedures and tests, and any other tests considered medically necessary or advisable based on the judgement of the physician or assigned designess. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

Signature_______________________________________________ Date___________________________

## BENEFITS AND FINANCIAL POLICY

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS TO THE DOCTOR OR APEX ORTHOPEDICS & SPORTS MEDICINE., a Divison of Signature Medical Group of KC, PA. I understand that I am financially responsible for any remaining balance due. A photo copy of this form shall be considered valid. (Initial here)___________

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Medicare Patients

IF YOU ARE A MEDICARE PATIENT, PLEASE SIGN BELOW FOR BENEFIT ASSIGNMENT MEDICARE LIFETIME CERTIFICATE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to APEX ORTHOPEDICS & SPORTS MEDICINE, a division of Signature Medical Group of KC, PA, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Administration and its agents any information needed to determine these benefits payable to related services.

Signature_______________________________________________ Date___________________________

We pledge to provide the highest quality care at the lowest possible cost regardless of insurance coverage or type. Insurance coverage and benefits vary by company and plan, and it is YOUR responsibility to verify your coverage, benefits, deductible, co-insurance and co-payments required prior to or after medical care is provided. Our office ‘participates’ with most insurance companies. In most cases, seeing a ‘Participating Provider’ has greater payment or services benefit to the patient. You must call your insurance company to verify our participation. If your insurance company requires a referral or other authorization prior to treatment for payment, it is YOUR responsibility to make sure it has been received, or you will be billed for services provided without a referral. If your insurance denies coverage, it does not preclude us from billing you for services provided.

If you have a Third Party Liability Claim, (Auto/MVA/Other Legal) you are responsible for payments prior to treatment; we will provide billing and claim information so you can file a claim with your insurance company. We will file one medical claim to your Auto Insurance for you.

If you do not have insurance, we require you to pay a deposit of $150 for your initial paitent visit, and a deposit of $75 for each subsequent visit, a deposit of $100 for injections/EMG/casting, and a deposit of $35 for post op xrays, prior to being seen by the medical care provider, the remaining balance will be billed to you. If you have a co-pay with your insurance company, it must be paid prior to being seen. Surgery Scheduling will collect a surgery fee deposit prior to scheduling your surgery to cover any unmet deductible and co-insurance as determinded by your insurance company. Payment for balance due for the portions your insurance company did not pay due to deductible, co-insurance, co-pay and non-covered services is due within 30 days of billing. Payment not received within 60 days may be sent to a collection agency. It is YOUR responsibility to contact our billing office if you are unable to pay your balance in full. Any insurace company billing or coverage disputes are YOUR responisibility and will not stop our collection efforts for payment of medical care provided.

**If you fail to pay the balance due on your account and it is sent to a collection agency a 15% collection fee will be added to the total to cover the cost of the collection agency service. (Initial here)_____________**

Payment can be made with Cash, Check, Money Order, and Credit/Debit Cards (Visa, Mastercard, Discover, & American Express), ACH and HSA cards or through our Patient Portal (www.c-ortho.com).

Signature_______________________________________________ Date___________________________