Prairie View Foot & Ankle LLC
5401 College Blvd. Suite 204
Leawood, KS 66211
Phone 913-233-8816
Fax 913-228-1190
www.prairieviewfootandankle.com

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Social Security #: _____

Patient Street Address: _____City:_____

State _____ Zip Code_____ Email: _____

Home Phone: _____Cell Phone: _____ Preferred phone (Home/Cell)

Gender: Male Female Marital Status : Single Married Divorced Widowed

Emergency Contact Name _____ Relationship _____ Phone _____

If patient is a minor, name of parent/guardian accompanying child today: _____

Employment Information

Status: Employed Unemployed Retired Disabled

Employer Name: _____ Occupation: _____

Primary Insurance:

Insurance Company Name: _____Policy #: _____Group #: _____

*If the subscriber is not the patient: Subscriber Name: _____ Subscriber Birthday:_____

Subscribers Address: _____

Relationship to Subscriber_____

Secondary Insurance:

Insurance Company Name: _____Policy #: _____Group #: _____

Primary Care Physician Name:_____

How did you hear about us? _____

Preferred Pharmacy Name_____ Location _____

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Patient Name _____ Today's Date _____

In order to protect your privacy and to comply with government regulations (HIPAA), we are 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.

RELEASE OF MEDICAL INFORMATION:

The physicians and staff at Prairie View Foot and Ankle may discuss my medical information and/or care with the following: (*Please list all names that apply.)*

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

MESSAGES:

I give my consent to the physicians and staff of Prairie View Foot and Ankle to leave/send a message to discuss treatment, surgery, lab, radiology results, or other information regarding my healthcare as follows: (*Please check all that apply.)*

____ On answering machine or voicemail at home.

____ On cell phone voicemail

____ Email through patient portal/medical record

____ I do not consent to messages being left at home, on my cell phone or by any other method

HIPAA CONSENT TO VIEW HISTORY OF PRESCRIPTIONS:

____ I give Dr. Sarah Russell/ Prairie View Foot and Ankle consent to view my prescription history.

Notice of Privacy Practices: As a condition of providing treatment to you, Prairie View Foot & Ankle obtains your consent to use and disclose protected health information about you to carry out treatment and payment. You may revoke this at any time by notifying us in writing. Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that Prairie View Foot and Ankle may use of your protected health information.

Signature: _____ Today's Date: _____

(Patient signature or parent of minor signature)

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OFFICE POLICIES

We appreciate you choosing Prairie View Foot and Ankle. We are committed to providing you with outstanding care. Outlined below are our office policies that we request you read and sign prior to receiving treatment.

Assignment of Insurance Benefits

I hereby authorize and assign my insurance carrier(s) to make payment directly to Prairie View Foot & Ankle LLC for insurance benefits for services rendered and otherwise payable to the insured. I authorize the use of my signature on all insurance submissions and claims. I understand and agree that I am financially responsible for all charges incurred including co-payments, co-insurance, deductibles, and non-covered services. I understand that it is my responsibility to verify with my insurance company that the physician treating me is covered under my insurance to get referrals and/or authorization for services as required.

Financial Policies

-Outstanding balances are due when you receive your statement or at your next visit, whichever is sooner. Your co-pay is due at each visit prior to seeing the doctor.

-Prior to your appointment, you must notify us if your injury is the result of a work-place injury. Your employer, workers compensation insurance company, or attorney must authorize your treatment in writing before your appointment.

-To cover the costs of our staff's labor, completion of each disability/FMLA/Insurance form requires a prepayment of $25. Please allow 7-10 business days from receipt of the prepaid fee for the forms to be completed.

-Any returned check from the bank for non-payment/insufficient funds shall result in the patient's account being charged a $25.00 fee per check returned

Termination of provider/patient relationship

-I understand that Prairie View Foot and Ankle has the right to discharge any patient from the practice at any time due to repeated non-compliance, failure to meet financial obligations, or threatening/violent/repetitive rude or offensive behavior. If this occurs, records will be released to a physician of my choice after a signed release of information is received by this office. I understand that this policy is to keep the provider/patient relationship trustworthy and respectful.

_____ _____

Signature Date