Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:

Required by government mandate [although you may refuse]:

Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer Information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for HARRISONVILLE FAMILY MEDICINE INC**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize HARRISONVILLE FAMILY MEDICINE INC to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for HARRISONVILLE FAMILY MEDICINE INC**

Signed_____ **Date:**_____

- **I authorize HARRISONVILLE FAMILY MEDICINE INC to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

Harrisonville Family Medicine, Inc,

Privacy Consent Form

(Check all that apply)

_____ Myself

_____ Spouse: _____

Family Member:

_____ ALL Adult Family Members

_____ ONLY: _____

_____ Parent or Family Member (For Minor Child)

Mother: _____

Father: _____

_____ May leave a detailed message on answering machine / voicemail

_____ NO Details on answering machine / voicemail – Only to call office

_____ Email: _____

_____ Consent to text (i.e. appt reminders, office closure due to weather or holidays, etc.)

_____ Other: _____

Note: It is your responsibility to notify HFM of any changes that need to be made to this form.

I acknowledge that by signing below, that I authorize Harrisonville Family Medicine, Inc. to disclose any information related to my / my child's care, with the choices I have indicated above. I also acknowledge that I have received and read a copy of HFM Notice of Privacy Practices.

_____ _____

Patient / Personal Representative Date

_____ _____

Relationship to Patient Witness

REVISED 11/10/2016

Past Medical History Form

Name: DOB:

Gastrointestinal
- Ulcer
- Colon Polyps
- Colon Infections
- Diverticulosis
- Diverticulitis
- Acid Reflux
- Hepatitis
- Liver Disease
- Irritable Bowel
- Crohn's

Endocrine
- Elevated Thyroid Levels
- Low Thyroid Levels
- Diabetes Type I
- Diabetes Type II

Pulmonary
- Environmental Allergies
- Chronic Lung Disease
- Chronic Bronchitis
- Chronic Sinusitis
- Asthma
- Sleep Apnea

Musculoskeletal
- Low Back Pain
- Gout
- Rheumatoid Arthritis
- Osteoporosis
- Osteoarthritis
- Fibromyalgia

Cardiovascular
- Coronary Artery Disease
- Atrial Fibrillation
- Previous Heart Attack
- Elevated Blood Pressure
- Hyperlipidemia
- Blood Clot
- Congestive Heart Failure

Genitourinary
- Kidney Stones
- Chronic Kidney Disease
- Urinary Tract Infections

NeuroPsych
- Seizure Disorder
- Stroke
- Attention Deficit Disorder
- Depression
- Anxiety
- Dementia
- Alzheimer's
- Bipolar Disorder
- Migraine Headache

Miscellaneous
- Anemia
- HIV Infection
- Glaucoma

Social History

Smoking Status:
- Current
  - How Often? _____
- Former
  - Quit Date? _____
- Never
- Alcohol Use _____

Male
- Elevated PSA
- Erectile Disorder
- Prostate Enlargement

Female
- LMP
- Last Pap Smear
- History of Abnl Paps
- # of Pregnancies
- Contraception
- Sexually Active

Personal History of Cancer
- Brain Cancer
- Thyroid Cancer
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Leukemia
- Lymphoma
- Ovarian Cancer
- Cervical Cancer
- Uterine Cancer
- Kidney Cancer

Family Medical History

	Relationship
Heart Attack	
High Blood Pressure	
Heart Disease	
Heart Failure	
Blood Clots	
Asthma	
Chronic Lung Disease	
Cancer	
Type: _____	
Diabetes	
Depression	
Anxiety	
Mental Illness	
Alcoholism	
Alzheimer's	
Seizure Disorder	
Migraine Headaches	
Stroke	
Kidney Disease	

Past Surgical History

Cardiovascular
- Aneurysm Repair
- Heart Bypass Surgery
- Carotid Artery Surgery
- Heart Valve Replacement
- Pacemaker
- Defibrillator
- Stent Placement

Musculoskeletal
- Hip Replacement
- Knee Surgery
- Knee Replacement
- Shoulder Surgery
- Rotator Cuff Repair
- Carpel Tunnel
- Lower Back Surgery
- Neck Surgery

Genitourinary
- Kidney Removal
- Kidney Stone Surgery
- Vasectomy
- Prostate Surgery

Gastrointestinal
- Appendectomy
- Gallbladder Removal
- Colectomy
- Colostomy
- Ileostomy
- Weight Loss Surgery
- Hemorrhoid Surgery
- Pancreas Surgery
- Spleen Removal

Hernia Repair
- Incisional
- Inguinal
- Umbilical
- Abdominal

Other
- Lung Surgery
- Thyroid Surgery
- Cateract Surgery
- Ear Tubes
- Tonsillectomy
- Adenoidectomy
- _____
- _____

OB/Gyn
- Total Abd. Hysterectomy
  - With Ovary Removal
- Vaginal Hysterectomy
- Tubal Ligation
- Cesarean Section
- Mastectomy
- Lumpectomy
- Breast Augmentation
- Breast Reduction

HARRISONVILLE FAMILY MEDICINE

2820 E. Rock Haven Road, Ste 100
Harrisonville, MO 64701
Phone (816) 380-3582 Fax (816) 380-6964

Patient Name | Social Security Number | Date of Birth

Releasing records ***FROM:*** _____
(physician or organization name)

_____
(mailing address, phone and fax number)

Releasing records ***TO:*** _____
(physician or organization name)

_____
(mailing address, phone and fax number)

Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)

_____ Confined to records for the time period of: _____

_____ Confined to records regarding the specific information: _____

_____ All records without regard to limitations placed on dates, history of illness, or diagnostic and therapeutic information, including AIDS testing or diagnosis, information or treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness.

For the purpose of: _____

This authorization is voluntary. This authorization will expire_____ (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I request that records be copied and sent to me that the office will send those records to me within thirty (30) days. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for those costs. I understand that once the requested records leave HFM, they are the responsibility of the patient/ recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/ recipient will be responsible for providing a flash drive for the electronic copy.

_____
Signature of Patient or Legal Representative | Date

_____
If Signed by Legal Representative, Relationship to Patient | Signature of Witness

Patient Name: _____ Patient DOB: ___/___/_____ Date

Wellness Update

Do you experience any of these symptoms?	*Yes*	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ Yes ☐ No

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc...)

Patient/Guardian Signature: _____ **Date:** ___/___/_____

Patient Phone: _____

FOR PROVIDER USE ONLY:
Order Allergy Test: ☐ Yes ☐ No
Date of last ENT exam: ___/___/_____

Provider Signature: _____ **Date:** ___/___/_____

Harrisonville Family Medicine, Inc.

Financial Policy
Effective Date: 7/1/2019

Thank you for choosing Harrisonville Family Medicine as your healthcare provider. Due to the changes in insurance reimbursements and high deductible health plans we are revising our financial policy to ensure we can continue to take care of your health needs and provide you with the best possible care. Please read the following information carefully.

This is an agreement between Harrisonville Family Medicine, Inc., as creditor, and the patient / debtor / responsible party. By executing this agreement, you are agreeing to pay for all services that are received.

Contracted Insurance: You are expected to pay deductibles and co-payments at the time of service. You must also pay outstanding balances prior to being seen in the office. **If you are not able to resolve an outstanding balance or pay the copay due before your next appointment, please be aware that your appointment will need to be rescheduled until your balance is paid in full or reasonable payment arrangements are made. If your appointment is rescheduled due to non-payment at time of check in there will be a $40 no show fee applied.** The deductible will be collected until your yearly deductible has been reached. It is your responsibility to know what is and what is not covered under your plan. It is the insurance company that makes the final determination of your eligibility and coverage. **You will be responsible for any and all charges not covered by your insurance company.**

Self-Pay Patients: Payment is expected at the time of service. If you cannot pay at the time of service, your appointment will be rescheduled.

Monthly Statements: If you have a balance of $10.00 or more on your account, we will send a monthly statement. **Please remember when you receive our statement you have already received quality care from your physician, your insurance has been filed and any payment or adjustment from your insurance company has been applied. The balance on your account is due and payable when the statement is issued.**

Past Due Accounts: Balances that remain on your account past 45 days are considered overdue and full payment will be expected at future appointments unless a payment plan has been arranged and approved by our billing department. Accounts over 90 days in arrears will be sent to our collection agency. At that point, for any new charges to be added to your account our office will require a credit card on file. Once an account has been placed in collections, the physician/patient relationship could be terminated and your records will be transferred to a physician of your choice.

Forms & Fees: Your portion of any form must be filled out completely before submitting it to us. A fee will be charged and collected when your form is returned to you or submitted on your behalf.

No Show Policy: A $40 fee will be charged for any missed appointment without 24 hour notice. This is not covered by insurance and must be paid prior to your next appointment. Multiple no shows in any 12 month period could result in termination from our practice.

Print Name: _____ **Signature:** _____ **Date:** _____

Revised 6/19/19

HIPAA Notice of Privacy Practices

Effective Date: 9/23/2013

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact HIPAA Compliance Officer, Tracey Roepke.

OUR OBLIGATIONS:
We are required by law to:

-Maintain the privacy of protected health information
-Give you this notice of our legal duties and privacy practices regarding health information about you
-Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:
As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to a Copy. You have a right to a copy of any Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Harrisonville Family Medicine, Inc. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Harrisonville Family Medicine, Inc.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Harrisonville Family Medicine, Inc.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Harrisonville Family Medicine, Inc. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Harrisonville Family Medicine, Inc. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.HarrisonvilleDoctors.com. To obtain a paper copy of this notice, request this at the front desk of Harrisonville Family Medicine, Inc .

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our HIPAA Compliance Officer, Tracey Roepke. All complaints must be made in writing. You will not be penalized for filing a complaint.