

Kansas City Bone & Joint Clinic, P.A.

Account# _____
(Office Use Only)

Patient Name: (Please Print) _____ Date of Birth _____

CONSENT: I hereby give my consent to any physician member of Kansas City Bone & Joint Clinic, P.A., or their designee to provide medical treatment to me, or to my minor child _____, encompassing diagnostic and therapeutic procedures. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations at this clinic.

RESPONSIBILITY FOR PAYMENT: I hereby acknowledge that any portion of the charge for services rendered or supplies provided by the physicians of Kansas City Bone & Joint Clinic, P.A., not paid by my designated insurance carrier, Medicare, or guarantor agency will be my responsibility to pay in full. I understand that I am responsible for furnishing valid referrals from my primary care physician when required. I understand that if I elect to visit a specialist physician and receive specialty services without a valid written referral when one is required by my insurance, then I am solely responsible for payment of services when rendered and/or supplies when provided.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT:
I acknowledge that I have received a copy of the Kansas City Bone & Joint Clinic, P.A., Notice of Privacy Practices.

AUTHORIZATION TO RELEASE INFORMATION: I here authorize this facility to release my Protected Health Information to:
Check all that apply:

Spouse Children _____ Others _____

AUTHORIZATION & ASSIGNMENT:

Insurance – I hereby authorize Kansas City Bone & Joint Clinic, P.A., and its Physicians to furnish to or receive from insurance companies and other health care provider, any and all information concerning my medical or physical condition, diagnosis and/or treatment. I hereby assign payment of medical/surgical benefits to the Kansas City Bone & Joint Clinic, P.A., for medical services rendered, or supplies provided, to myself or my dependents.

Medicare – I request that payment of authorized Medicare benefits otherwise payable to me, be made on my behalf to Kansas City Bone & Joint Clinic, P.A., for any services or supplies furnished to me by that physician. I authorize the Kansas City Bone & Joint Clinic, P.A., physicians and authorized personnel to release to the Centers for Medicare and Medicaid Services and its agents, any medical information needed to determine benefits payable for related services or supplies.

Sign Here → Patient Signature: _____ Date _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE – (MEDICARE PATIENTS ONLY!) OMB No. 0938-0214

| | YES | NO |
|--|-------|-------|
| 1. Is the patient a Veteran? | _____ | _____ |
| a. Did the VA Refer you here for treatment? | _____ | _____ |
| b. Does the patient have a VA “fee basis ID card?” | _____ | _____ |
| 2. Do you have a Federal Black Lung card? | _____ | _____ |
| 3. Is this medical condition due to an accident of any kind? | _____ | _____ |
| If yes, was it: Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Injured in own home <input type="checkbox"/> Other <input type="checkbox"/> | | |
| 4. Is the patient covered by an employer’s health insurance plan through their own employment or that of a family member? (Not retiree coverage) | _____ | _____ |