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Richard A. Steckley, M.D.
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CARDIOVASCULAR CONSULTANTS OF KANSAS, INC.

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Wichita, KS 67226
(316) 265-1308 - 1-800-362-1093 toll free

Roger W. Roberts, D.O.
Michael F. Lloyd, D.O.
Jason T. Tauke, M.D.
Aziz R. Maksoud, M.D.
Dhaval R. Parikh, M.D.

Patient Registration Information

(DO NOT WRITE IN THIS BOX)

ACCOUNT #	DR. #	REFERRING DR. #	LOCATION & NO. #	DIAGNOSIS #

DATE: _____

PATIENT NAME: _____ SOCIAL SECURITY NO.: _____
LAST FIRST MI.

ADDRESS: _____ AGE: _____
STREET/BOX CITY STATE ZIP

PHONE NO. ( ) _____/_____ SEX: ☐ MALE ☐ FEMALE - DATE OF BIRTH _____/_____/_____
AREA CODE HOME CELL MO DAY YR

PLACE OF EMPLOYMENT: _____ PHONE NO. ( ) _____

ADDRESS OF EMPLOYER: _____

SPOUSE'S NAME: _____ SSN # _____DATE OF BIRTH_____

PLACE OF EMPLOYMENT: _____ TELEPHONE # _____

EMPLOYER'S ADDRESS _____

NAME OF NEAREST RELATIVE
NOT LIVING WITH PATIENT _____ RELATIONSHIP _____

ADDRESS _____ TELEPHONE NO. _____

PRIMARY DOCTOR _____

PRIMARY INSURANCE: _____
COMPANY NAME AND ADDRESS

INSURED'S NAME _____ DATE OF BIRTH_____ INSURED (POLICY HOLDER) RELATIONSHIP TO PATIENT _____

POLICY OR GROUP NUMBER: _____ IS THIS INSURANCE THRU EMPLOYER? ☐ YES ☐ NO

SECONDARY INSURANCE: _____

INSURED'S NAME _____ DATE OF BIRTH_____ RELATIONSHIP TO PATIENT _____

POLICY OR GROUP NUMBER: _____ IS THIS INSURANCE THRU EMPLOYER? ☐ YES ☐ NO

☐ NO INSURANCE: I UNDERSTAND I AM RESPONSIBLE FOR THIS BILL, INITIALS _____

PATIENT CONSENT TO DISCLOSE HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our Privacy Officer at 9350 E. 35th Street North, Suite 101, Wichita, KS 67226 or phone 316-265-1308.

You have the right to request that we restrict how protected health information about you is used or disclosed for care, services, payment or health care operations. We are not required to agree to this restriction, but if we do, we will honor our agreement, consistent with applicable law.

By signing this form, you consent to our use and disclosure of protected health information about you for care, service, payment and health care operations. You have the right to revoke this Consent, in writing, except to the extent that we have already made disclosures in reliance on your prior consent.

AUTHORIZATION TO PAY BENEFITS: I AGREE TO ASSIGN BENEFITS TO CARDIOVASCULAR CONSULTANTS OF KANSAS, INC. AND **I UNDERSTAND I AM RESPONSIBLE FOR ANY UNPAID BALANCE**

DATE: _____

_____
Patient/Patient Representative

_____
Relationship to Patient