Kansas Heart Office Plaza
9350 E. 35th St. N. ◦ Suite 101
Wichita, KS 67226

CARDIOVASCULAR CONSULTANTS OF KANSAS, P.A.

Office: 316-265-1308
In Kansas: 1-800-362-1093
Fax: 316-265-4480

DATE: _____

PATIENT		SPOUSE	
LAST NAME (PLEASE PRINT)		LAST NAME (PLEASE PRINT)	
FIRST NAME	MIDDLE INITIAL	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS		STREET ADDRESS	
CITY, STATE	ZIP CODE	CITY, STATE	ZIP CODE
HOME NUMBER	CELL PHONE	HOME NUMBER	CELL PHONE
SOCIAL SECURTIY NUMBER		SOCIAL SECURITY NUMBER	
EMPLOYER		EMPLOYER	
SEX	MARITAL STATUS	SEX	MARITAL STATUS
BIRTHDATE	AGE	BIRTHDATE	AGE
NAME AND PHONE NUMBER OF PERSON NOT LIVING WITH YOU, TO CONTACT IN CASE OF EMERGENCY NAME: PHONE NUMBER:			

INSURANCE INFORMATION	
PRIMARY INSURANCE CO.	SECONDARY INSURANCE CO.
ADDRESS	ADDRESS
INSURANCE I.D. #	INSURANCE I.D. #
SUBCRIBER'S NAME	SUBCRIBER'S NAME
SUBCRIBER'S BIRTHDATE	SUBCRIBER'S BIRTHDATE
RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____	

KANSAS HEART HOSPITAL OWNERSHIP

The 2010 Health Care Act requires all patients to know that the Kansas Heart Hospital is partially owned by physicians who are members of Cardiovascular Consultants of Kansas (CC of K), our medical practice group.
Via Christi medical center owns 49% and CC of K physicians own less than 15%.
Your signature acknowledges that you have been informed of the above information. Thank you for your compliance with this federally mandated healthcare regulation.

PATIENT SIGNATURE **DATE**

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RELEASE OF MEDICAL INFORMATION

Authorization to pay benefits to physician: I hereby assign payment directly to Cardiovascular Consultants of Kansas for the medical benefits, if any, otherwise payable to me for services described, but not to exceed my indebtedness to Cardiovascular of Consultants of Kansas for those services.
Insurance Information Release Authorization: I hereby authorize Cardiovascular Consultants of Kansas to release any information acquired in the course of my examination or treatment to my insurance company and/or employer.
Financial Agreement: I understand I am responsible for all fees, regardless of insurance coverage.
Notice of Privacy Policy: By signing, I acknowledge I have received or was offered a copy of the Notice of Privacy Practices for Cardiovascular Consultants of Kansas, PA.
RX History: I understand and give consent to Cardiovascular Consultants of Kansas, PA. to access my prescription medication history from other providers and/or pharmacies.

If you would like your medical information released with anyone, other than yourself and your doctor, they must be listed below. (i.e. spouse, children, siblings, emergency contact)

NAME	**RELATIONSHIP TO PATIENT**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ Patient elected not to allow release of medical informaiton to any other person/persons other than themselves or their doctor.

_____ _____
Paitent Name (please print) Paitent Date of Birth

_____ _____
Signature of Patient/Legal Representative Date