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: _____ PHYSICIAN: _____

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

INSURANCE INFORMATION

PRIMARY INSURANCE CO.		SECONDARY INSURANCE CO.	
ADDRESS		ADDRESS	
INSURANCE I.D. #	GROUP #	INSURANCE I.D. #	GROUP #
POLICYHOLDER'S NAME		POLICYHOLDER'S NAME	
POLICYHOLDER'S DATE OF BIRTH		POLICYHOLDER'S DATE OF BIRTH	
RELATIONSHIP TO POLICYHOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		RELATIONSHIP TO POLICYHOLDER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____	

ATTENTION MEDICARE PATIENTS

1. Are you receiving Black Lung Benefits? ____ Yes ____ No
2. Are these services to be paid by a government research program?____ Yes ____ No
3. Has the Department of Veterans Affairs authorized and agreed to pay for your care at this facility? ___Yes ___ No
4. Was the illness/injury due to a work-related accident/condition?____ Yes ____ No
5. Do you have group health insurance coverage, due to your own or your spouse's employment?____ Yes ____ No
6. If yes, does the employer that contributes to the group health plan employ 20 or more employees?____ Yes ____ No

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits made either to me or on my behalf to Cardiovascular Consultants of Kansas, P. A. for any services provided to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits payable for related services.

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.

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.

If you would like your medical information released to anyone other than yourself or your doctor, list their name and relationship to you under option one.

If you elect not to have your information released to anyone other than yourself or your doctor, select option two.

OPTION ONE:

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

OPTION TWO:

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

_____
Patient Name (please print)

_____ _____
Signature of Patient/Legal Representative Date