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

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ Primary Care Physician: _____

Social Security Number: _____ Email: _____

Street Address: _____

City/State: _____ Zip Code: _____

Home Phone #: _____Cell Phone #: _____ Carrier: _____

How would you like to be reminded of your appointment? _____Text _____Email

Sex: _____ Marital Status: _____

Spouse Name: _____ Spouse Date of Birth: _____

Spouse Cell Phone #: _____

Medical Power of Attorney: Yes_____ Name: _____ No_____

Emergency Contact Information

Name: _____ Phone #: _____ Relationship: _____

Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Patient's Relationship to Policy Holder: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Patient's Relationship to Policy Holder: _____

Attention Medicare Patients Only

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

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One Time Authorization for Medicare Patients

I request 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.

Patient Signature: _____ Date: _____

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.

Release of Medical Information

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.
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 to anyone other than yourself or your doctor, they MUST be listed below. (i.e. Spouse, Children, Siblings, Emergency Contact)

If you elect not to have your information released to anyone other than yourself or your doctor, select NO.

_____**YES**, Please release my medical information to the following:

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

_____ **NO**, DO NOT allow release of medical information to any other person(s) other than myself or doctor/staff.

_____

Patient Name (Please Print) Date of Birth

_____

Signature of Patient/Legal Representative Date