



Updated: ____/____/____ Primary Care Physician: _____ Referring Physician: _____

Last Name: _____ First: _____ MI: _____

Date of Birth: ____/____/____ Age: _____ Gender: _____

Address/City/State/Zip _____

Home Phone: _____ Cell Phone: _____ Social Security: _____

Responsible Party. (if other than patient): _____ Relationship to Patient: _____

Race: *please check one* White Asian African American American Indian or Alaska Native Native Hawaiian or other Pacific Islander
 other Decline to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refused to report Primary language: English Spanish Interpreter needed? Yes No

Email Address for Web Portal: _____ Pharmacy of Choice/Location: _____

Emergency Contact: _____ Phone Number: _____

How would you like to receive appointment reminders:(*please check one*) Home number Cell number

HEALTH INSURANCE***

Primary Insurance: _____ Secondary Insurance: _____ ID

Number: _____ Group Number: _____ ID Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder: _____

*** If you do not present a copy of your insurance card, you will be responsible for all office and surgery charges incurred until we receive a copy of the front and back of the card(s).

Insurance Policy Holder (other than self)

Name: _____ Date of Birth: ____/____/____ Social Security: _____

Address/City/State/Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to Patient: _____ Employer: _____

Insurance Authorization & Assignment/Consent to Treatment: I hereby authorize St. Joseph/St. Mary's Medical Group to furnish information to insurance carriers concerning my dependents illness or myself and treatments and I hereby assign to the physician (s) all payments for medical services to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. (Must be signed regardless of insurance coverage)

Signature _____ Date: ____/____/____

Lifetime Consent - Medicare Patients Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to St. Joseph/St. Mary's Medical Group for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the healthcare financing administration and it agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date: ____/____/____



Consent for Treatment

These PLEASE READ authorizations EACH must AUTHORIZATION be signed by CAREFULLY. the patient or by the authorized representative for a minor or an incapacitated patient.

1. **Authorization for Treatment.** I hereby authorize the attending physician and any consulting physician, and other practitioners designated by them to prescribe treatment, to administer medication, and to perform such procedures and tests as may be deemed advisable or necessary in the diagnosis and treatment of this patient during this hospitalization. I understand that no promise, guaranty or warranty has been made regarding the results of medical treatment or procedure. I realize that medical, nursing and other health care personnel in training attend to patients and unless requested otherwise, may be present during patient care as a part of their education. Still or motion pictures and closed circuit television monitoring of patient care also may be used for educational purposes, unless I expressly request otherwise.
2. **Authorization to Release Information**
 - a. I authorize the release of any or all portions of my medical records concerning this admission to any health care practitioner or facility that may be designated by my physician for the purpose of providing continuity of care.
 - b. I authorize any company health care providers to disclose medical information pertaining to treatment of the undersigned patient during this hospitalization to the appropriate health insurance company, patient financial assistance organization, and review organization that is necessary for the purposes of certification, payment of medical expenses, and discharge planning. I authorize the disclosure of information related to treatment for drug or alcohol abuse, mental health diagnoses, genetic conditions, or the presence of a communicable disease such as hepatitis or HIV/AIDS. I understand such disclosures could result in limitation or denial of insurance benefits or third party reimbursement or could otherwise be harmful to the patient's interest.
 - c. I authorize hospital and any health care providers to disclose medical information pertaining to my treatment during this hospitalization that relates to an injury for which workers' compensation benefits may apply and where workers' compensation is stated as the primary payor.
 - d. In the event the patient is transferred during this hospital admission, I authorize this hospital and all attending or treating practitioners to transfer copies of all medical records of the patient for this admission to any other hospital or healthcare facility to which the patient may be transferred.
3. **Personal Valuables.** The Clinic shall not be liable for the loss or damage to any money, jewelry, eyeglasses or contact lens, dentures, documents or other personal property while the patient is on site. If patient is going to have an outpatient procedure in the clinic, please leave personal belongings with a friend or family member.
4. **Financial Responsibility**
 - a. The undersigned financially responsible party understands and agrees that The patient's health care providers are not responsible for collection insurance nor for resolving any disputed insurance or other third party payer claims, and promises to pay hospital and health care providers all costs and charges incurred in connection with the patient's hospitalization pursuant to this admission.
 - b. I understand it is my responsibility to make sure any referrals or pre-certifications required by my insurance plan have been completed prior to this service or within the plan's specified time frames.
 - c. I understand that I may be asked for co-payments or a deposit at the time of my registration, depending on my insurance coverage.
5. **Medicare/Medicaid Certification and Authorization.** Each of the undersigned certify that the information given in applying for payment under Title XVIII or XIX of the Social Security Act, if applicable, is correct. Any holder of medical or other information about the patient pertaining to this hospital admission is authorized to release to the Social Security Administration or the State of Missouri, as applicable, or their intermediaries any information needed for any Medicare/Medicaid claim and to furnish medical or other information pertaining to this admission acquired through their intermediaries under Title XVII or XIX as necessary to process any complementary claim.
FOR INPATIENT ADMISSIONS ONLY: If I am a Medicare beneficiary, I have received on this date, the 'Important Message from Medicare' letter.
6. **Assignment of Insurance and Third Party Benefits.** I authorize direct payment to the hospital and associated physicians, any insurance benefits otherwise payable to the undersigned or patient. I authorize the hospital and associate physicians to communicate with my employer and insurance company for the purpose of determining the existence and extent of such benefits. I agree and understand that the patient is financially responsible to the hospital and associated physicians for the charges not satisfied by this assignment and may be subject to interest fees, court costs and a collection fee.
7. **Independent Status of Medical/Dental Staff.** I recognize that members of the Medical/Dental staff, or the medical students (under the supervision of a member of the Medical/Dental staff), and allied health professionals who furnish services to me during this admission are independent providers and are NOT AGENTS OR EMPLOYEES OF THE HOSPITAL. I understand and agree that each of the above referenced practitioners (such as radiologists, pathologists, anesthesiologists, etc.) who render professional services to me bill and collect independently for these services. I understand that their bills will be separate and apart from the Hospital's billing and collections or that the hospital may bill on the physician's behalf, but subject to the authorizations by me in accordance with this agreement.

The undersigned certifies that they have read, understand and have had the opportunity to ask and receive answers to questions prior to signing.

Signature of Patient / Parent / Conservator / Guardian: _____ Date: ____/____/____



Voluntary Prior Express Consent Form

I understand that by engaging the services of Prime Healthcare Services, "Service Provider" it will be important for Service Provider or the "Authorized Entities" (as defined below) to be able to communicate with me and have current contact information for me.

Authorized Entities: The term "Authorized Entities" shall mean the above referenced Service Provider, billing service(s), collection agencies, debt collectors and any related health care provider, physician, service provider, contractor, independent contractor, including, but not limited to, those that are located at the same physical location as Service Provider or to which Service Provider has referred services, and each of their respective successors, assigns, agents, representatives, employees, partners, parents, subsidiaries, affiliates, and billing service(s), collection agencies, or debt collectors of any of the previously listed persons/entities and all corporations, persons, or entities in contract with any of them.

Voluntary Communication Consent: I hereby voluntarily grant consent for Service Provider or the Authorized Entities to contact me, my spouse, and where applicable legal guardian or representative, using an automatic telephone dialing system or an artificial or prerecorded voice, via e-mail, or via SMS text messages and any other forms of electronic communication. I also give my voluntary express consent for the Authorized Entities to communicate with me for any reason at any telephone or cellular phone number or email address I provide or may utilize, regardless of how Service Provider or the Authorized Entities obtains such contact information. Service Provider and Authorized Entities will treat any email address I provide as my private email address that is not accessible by unauthorized third parties.

I understand that my agreement to the terms of this Prior Express Consent Form is optional and not a condition of any Service Provider or Authorized Entity's willingness to provide services to me. I further promise to notify Service Provider and Authorized Entities if any telephone number, email address or other contact information that I provided to Service Provider or the Authorized Entities changes or is no longer used by me. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to Service Provider and any Authorized Entities that contact me.

I hereby consent and authorize that a photocopy of this authorization may be considered as valid as the original.

I **DO NOT** grant consent for Service Provider or the Authorized Entities to contact me, my spouse, and where applicable legal guardian or representative, using an automatic telephone dialing system or an artificial or prerecorded voice, via e-mail, or via SMS text messages and any other forms of electronic communication.

Signature: _____ Date: ____/____/____

Relationship to Patient: Patient / Parent / Conservator / Guardian: _____



Medical Information Authorization

Name: (Please Print) _____ Date of Birth: ____/____/____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and/or request a copy of the Prime Healthcare Medical Groups Notice of Privacy Practice on the date indicated. If you have any questions regarding the information in the Prime Healthcare Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Medical Group's Patient Privacy Officer as indicated on your Notice.

**The above authorization is required by Federal Law under HIPAA regulations.*

Medical Information Authorization

* I DO NOT authorize my medical care Provider to leave a voicemail message on my phone which I provided to you in my demographic information.

* I DO authorize my medical care Provider to leave a voicemail message on my phone which I provided to you in my demographic information.

* I DO NOT authorize the physician or anyone associated with his/her group to discuss my medical condition, treatment or test results with anyone other than myself.

* I DO authorize the physician or anyone associated with his/her medical Group to discuss my medical condition, treatment and test results with the following people (family/friends, not to include physicians):

Name: _____ Phone: _____ Relationship: _____

Any Info regarding my health/appointments/insurance Only info regarding: _____

Name: _____ Phone: _____ Relationship: _____

Any Info regarding my health/appointments/insurance Only info regarding: _____

Name: _____ Phone: _____ Relationship: _____

Any Info regarding my health/appointments/insurance Only info regarding: _____

Name: _____ Phone: _____ Relationship: _____

Any Info regarding my health/appointments/insurance Only info regarding: _____

Signature of patient or legal representative: _____ Date: ____/____/____

Printed name of patient/legal representative: _____ Relationship: _____



St. Joseph Medical Center
St. Mary's Medical Center

Patient Rights and Responsibilities

You, the patient, have the right: To treatment without discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation and gender identity or expression. To expect a family member and your doctor will be informed you are a patient at the medical center. To be treated with dignity and respect in a safe, clean setting, free from abuse, neglect or harassment. To know the identity of doctors, nurses and others involved in your care and you have the right to know when they are students, residents or other trainees. To receive information about what is expected of patients and where you can take complaints. Patients can freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services. To privacy and confidentiality within the limits of the law. (Your rights are described in the Notice of Privacy Practice.) To be told about your illness or injury, the benefits and risks of each treatment, what to expect during treatment and how well you may recover. This information must be given in terms you can understand, so you can give permission before treatment begins. (Except in emergencies when the patient is not conscious or not able to communicate and the need for treatment is urgent.) To request a review by the hospital's Ethics Committee about an ethical issue related to your care. To refuse treatment, if the law allows, and to be told by your doctor what might happen medically, because of your decision. To be told if anything unexpected and significant happens during your medical center stay and any resulting changes in your care. To have your report of pain acknowledged and treated as appropriate. To be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff. To be informed about advance directives and to receive assistance in completing one. This will include naming someone to make decisions about your care if you are not able to. (You will receive treatment even if you do not have an advance directive.) To receive care to make you as comfortable as possible if you are dying, including your spiritual needs regarding death. To have access to space and be allowed to talk privately with people outside of the medical center, whether in person, by mail, or telephone, appropriate to your needs, care, treatment and services. To have access to a medical center interpreter. To have a family member, friend or other representative of your choice present with you for emotional support during your stay. To be told of any research being done related to your care, and to either agree or refuse to be part of the research. To be active in your plan of care, before, during and after your medical center stay, and to be told of choices available to you for health care services after leaving the medical center. To receive help identifying sources of follow up care, and to let you know if our medical center has a financial interest in any referrals. To file a complaint about any part of your care and to know what happened as a result of your complaint. To be allowed to see or get a copy of your medical record as allowed in the hospital's policy. (Written request, 24 hours in advance.) To ask for a detailed copy of your bill, even if insurance is paying. (Contact the Business Office at 816-943-2192.) To be informed of the medical center programs available to you if you are experiencing domestic or intimate partner violence. Call 816-461-4673, and ask for the Bridge Span Advocate, or call the Metro Wide Domestic Violence Hotline at 816-HOTLINE (468-5463). Even if the patient is able to make his/her own decisions, they may appoint a representative to exercise these rights on their behalf. If the patient is not able to make his/her own decisions, is legally incompetent or is a minor, an authorized representative including a guardian can exercise these rights on the patient's behalf.

You have the responsibility: To provide, to the best of your ability, accurate and complete information about your condition, past illnesses, hospitalizations, medication, dietary supplements, past allergic reactions, etc., related to your health. To be aware of financial consequences of using uncovered services or out of network providers and any network or admission requirements under your health plan. To inform physicians, nurses or other health professionals of any change in your condition or reaction to your treatment, or any special needs during your visit, such as spiritual care, interpreters, etc. To ask questions if you do not understand your medical plan of care or treatment instructions. To follow the instructions of health care providers involved in your care. To accept responsibility if you choose to refuse treatment. To be respectful of the rights of other patients, staff and property of the medical center. To follow medical center rules and regulations affecting patient care, safety and visiting hours. You also have the responsibility to not threaten physical violence or aggression of any kind against staff or facility. Should threats or threatening behaviors occur it is grounds for immediate termination with all of facilities in our network. St. Joseph Medical Center and St. Mary's Medical Center are smoke free facilities.

Prime Healthcare is committed to providing quality care to our patients. Physicians' clinical decisions about the patient's care are based on patient needs and not affected by the method of payment between the Medical Center and providers. If you have any questions regarding your patient rights and responsibilities, or have a request, concern or complaint, please contact:

St. Joseph Medical Center
Patient Representative 1000
Carondelet Drive Kansas City
64114 816-943-4771

St. Mary's Medical Center
Patient Representative 201 NW
R D Mize Rd Blue Springs MO
64014 816 655 5707

State Survey Agency:
Health Standards and Licensure
Dept of Health and
Senior Services
PO Box 570
Jefferson City MO 65102
573-751-6303 or 800-392-0210
health.mo.gov/askus.php

Accreditation Agency:
The Joint
One Renaissance
Oakbrook Terr II
800-994-6610
jointcommission.org

The undersigned certifies that they have read, understand and have had the opportunity to ask and receive answers to questions prior to signing.

Signature of Patient / Personal Representative: _____ Date: ____/____/____



I. Illness or Injury Caused by an Accident

1. Is the reason for today's outpatient or inpatient admission due to any type of accident?

o **No** - proceed to question #2.

o **Yes** - If the answer is yes, Medicare may be secondary. Ask the patient the following questions:

a. Date of accident: ____/____/____

b. Type of accident:

o Motor vehicle (*patient at fault*) - note name and address of patient's automobile insurance company and policy number. _____

*****Patient's automobile insurance is primary*****

o Motor vehicle (patient not at fault) - note name and address of third party's automobile insurance company and policy number. _____

*****Third Party's automobile insurance is primary*****

o Work Related - note name of worker compensation carrier, address and claim number.

*****Worker compensation carrier is primary*****

o Other Accident (e.g., slip and fall) - note name of liability insurer or attorney, address and claim number or state if not applicable.

*****Liability Insurer is primary unless not applicable*****

II. Coverage Through Other Government Entity

2. (a) Does the patient have coverage through the Department of Labor's Black Lung Program or any federal or state program (excluding state welfare?)

o **No** - proceed to question #3.

o **Yes** - note the date benefits began (CCYY/MM/DD) and name and address of government entity:

Date: ____/____/____ Name/Address _____

*****If the patient answered yes, government program is primary*****

(b) Has the Department of Veteran's Affairs (DVA) authorized and agreed to pay for care at this hospital?

o **No** - Medicare is primary.

o **Yes** - the OVA is primary.

III. Medicare Eligibility and Coverage Based on Patient's Age 3.

3. (a) Is the patient 65 years old or older?

o **No** - answer questions #4 and #5 only.

o **Yes** - answer questions b, c and d only.

(b) Is the patient currently employed?

o **No** - give the patient's retirement date (CCYY/MM/DD): Date: ____/____/____

o **Yes** - note name and address of employer: _____ (c)

Is the patient spouse currently employed?

o **No** - give the patient's retirement date (CCYY/MM/DD): Date: ____/____/____

o **Yes** - note name and address of employer: _____



III. Medicare Eligibility and Coverage Based on Patient's Age 3.

(d) Is the patient spouse employed by a company with 20 or more employees and a GHP which provides benefits for the patient?

No - Medicare is primary.

Yes -GHP is primary. Note the following:

Name and address of GHP: _____

Identification and group number: _____

Policyholder's relationship to patient: _____

IV. Medicare Eligibility and Benefits Based on Disability

4. (a) Is the patient, spouse, family member or guardian employed by a company with 100 or more employees and a GHP which provides benefits for the patient?

No - Medicare is primary.

Yes - GHP is primary. Note the following information:

Name and address of Employer: _____

Name and address of GHP: _____

Identification and group number: _____

Name of employee and relationship to patient: _____

V. Medicare Eligibility and Benefits Based on End Stage Renal Disease (ESRD)

5. (a) Has the patient had a kidney transplant:

No

Yes - provide date (CCYY/MM/DD): Date: ____/____/____

(b) Has the patient received maintenance dialysis treatments?

No

Yes - provide date dialysis began (CCYY/MM/DD): Date: ____/____/____

(c) Has the patient participated in a self-dialysis training program?

No

Yes - provide date dialysis training began (CCYY/MM/00): Date: ____/____/____

(d) Does the patient have GHP?

No - Medicare is primary.

Yes - Note the following:

Name and address of GHP: _____

Identification and group number: _____

Name of Policyholder and relationship to patient: _____

Name and address of GHP employer (if any): _____

(e) Is the patient within the 30 month coordination period:

No - Medicare is primary.

Yes - Proceed to "F" below.

(f) Is the patient entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

No - GHP is primary during the 30 month coordination period.

Yes - Proceed to "g" below.

(g) Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

No - initial entitlement was based on age or disability, proceed to "h" below.

Yes - GHP is primary during the 30 month coordination period.

(h) Does the working aged or disability MSP provision apply (in other words, is the GHP primary based on the patient's age or disability entitlement)?

No - Medicare is primary.

Yes - GHP is primary and continues to pay primary during the 30 month coordination period.

Patient or Representative Signature: _____

Date: ____/____/____

Witness: _____

Date: ____/____/____



Financial Policy & Benefit Assignment

We are committed to providing you with the best healthcare. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility to pay.

- All new patients must complete our Patient Information form before seeing their provider, and at the beginning of every new year.
- You will also need to make updates to your demographic information if your address, phone number, insurance, or family status has changed throughout the year. These updates are the patient's responsibility.
- Failure to update your demographic and/or insurance information can lead to denied claims. Denied claims become the patient's responsibility.

Insurances

Insurance is a contract between you and your insurance company. Your insurance company will list the required co-pay for each visit on your card. Depending on your plan, your card might also list a Primary Care Physician (PCP) and that referrals are needed for any services outside your primary care office. Please check before visiting specialists' offices. For most plans, seeing a specialist without a referral will result in non-payment of the visit.

We will be glad to bill any secondary insurance on your behalf, but if payment is not received within 60 days, it will become patient responsibility.

Co-Payments

Co-payments are due at the time of service and are a requirement of your insurance company. Failure to bring your required co-pay may result in your appointment being rescheduled. During the course of your visit, if your provider adds additional services, this may result in an additional copayment required by your insurance carrier. For example, if your appointment is for a wellness visit, and the provider ends up doing an additional service, such as treating you for a new diagnosis or addressing a previous issue, although you may not have had a copayment for the wellness a visit, the additional service will likely require a copayment that you will be responsible for.

Self-pay

Patients without health insurance can qualify for a "Prompt Pay Discount" by paying 50% of the charge on the date of service. The other remaining 50% will be eliminated. Notice will be sent to the billing office of this discount.

Prompt pay discounts apply only to the office visit charge and do not include labs, in house testing or injections. Specimens that require being sent out to a lab, will be billed directly to you by the lab company. For pricing on specific tests, please call the lab of your choice and specify at time of collection what lab you want your specimen sent to.

No Show and Continual Cancellations

There will be a \$25 fee for "no shows" (not showing up for your appointment) and for cancellations or reschedules made less than 24 hours before your appointment unless approved by the Practice Manager. Continual no shows and cancellations may result in you being asked to discontinue care at our practice.

Patient Signature: _____ Date: ____/____/____