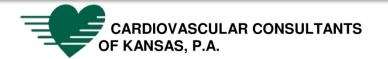
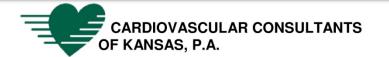
Kansas Heart Office Plaza 9350 E. 35th St. N. • Suite 101 Wichita, KS 67226



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		ITIAL	FIRST NAME		MIDDLE INITIAL
BIRTHDATE			BIRTHDATE		
ADDRESS			ADDRESS		
CITY, STATE ZIP CODE		Е	CITY, STATE		ZIP CODE
HOME NUMBER CELL PHONE		HOME NUMBER	CE	LL PHONE	
SEX MARITAL STATUS			SEX		
SOCIAL SECURITY NUMBER			SOCIAL SECURITY NUMBER		
EMPLOYER	EMPLOYER PI		EMPLOYER	EMPLOYER PHONE	
NAME AND PHONE NUMB	ER OF PERSON NOT L	IVING V	VITH YOU TO CONTACT	IN CASE	E OF EMERGENCY
NAME:	RE	ELATION	NSHIP:	PHONE	#:
PRIMARY CARE PROVIDE	R		ADDRESS		
	INSURA	NCE IN	FORMATION		
PRIMARY INSURANCE CO.		ECONDARY INSURANCE CO.			
ADDRESS A			DDRESS		
INSURANCE I.D. #	GROUP#	П	NSURANCE I.D. #		GROUP#
POLICYHOLDER'S NAME		P	OLICYHOLDER'S NAME		
POLICYHOLDER'S DATE OF BIRTH P			OLICYHOLDER'S DATE OF BIRTH		
			ELATIONSHIP TO POLICYHOLDER SELF SPOUSE CHILD OTHER		
SEEL STOCKE CON			CARE PATIENTS		
2. Are these services to be 3. Has the Department of V 4. Was the illness/injury de 5. Do you have group heal 6. If yes, does the employed I request that payment of authorizany services provided to me. I aut services and its agents any inform	c Lung Benefits? Yes paid by a government resear Veterans Affairs authorized a ue to a work-related accidenth insurance coverage, due to that contributes to the ground NE TI ed Medicare Benefits made whorize any holder of medical	No rch progra and agreed t/conditior o your ow up health p ME AUT either to main formati	m?YesNo to pay for your care at this fact to pay for your care at this fact to pay for your spouse's employment that employ 20 or more employ HORIZATION the or on my behalf to Cardiova on about me to release to the C	yees?Yes	s No Yes No sultants of Kansas, P. A. for
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 rother than themselves or their doctor.	release of medical info	ormation to any other person/persons
Patient Name (please print)		
Signature of Patient/Legal Representa	tive	Date