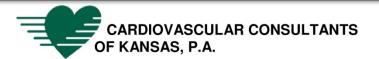
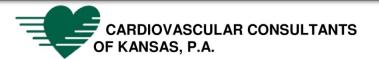
Kansas Heart Office Plaza 9350 E. 35th St. N. • Suite 101 Wichita, KS 67226



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

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 rem	inded of your appointment?	TextEmail		
Sex: Marital Status:				
Spouse Name:	Spouse Date of Birth:			
Spouse Cell Phone #:				
Medical Power of Attorney: Y	es Name:	No		
Emergency Contact Info	rmation			
Name:	Phone #:	Relationship:		
Insurance Information				
Primary Insurance Company:				
Policy Number:	Group N	umber:		
Policy Holder Name:		Date of Birth:		
Patient's Relationship to Polic	y Holder:			
Secondary Insurance Company	/:			
Policy Number:	Group N	(umber:		
Policy Holder Name:		Date of Birth:		
Patient's Relationship to Polic	y Holder:			
Attention Medicare Patients Only				
 Are these services to be pai Has the Department of Veto Was the illness/injury due to 	<pre>ung Benefits? Yes No d by a government research program?</pre>	Yes No ay for your care at this facility?Yes No 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 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