Advanced Mobile Healthcare & Community Clinic
701 N. Goddard Rd St. A
Goddard, Ks. 67212
Ph: (316) 794-2663
Fax: (316) 794-2669

437 Cedar St
Kingman, Ks 67068
Ph:(620)-553-5040
Fax: (620)-553-5029

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information will be released for the patient as indicated below, on completion of authorization.

Last Name First Name MI Maiden/Other Name Date of Birth

Street Address City State/Zip Phone Number

In making a request for medical information, please check one of the two options below:

- You are the patient, the patient's designated personal representative or the patient's guardian.
- You are affiliated with AMHCC and so authorized to request medical information on behalf of the patient for further treatment. NOTE : Healthcare providers may request medical information from another provider for further treatment as codified at *45 CFR 164.506(b)2 and (c)2* of the HIPAA Privacy Rule.

The information to release will cover the period from _____ to _____

Purpose of release (***REQUIRED***): • Continuation of Care • Personal Reasons • Insurance • Legal
• Other (fill-in): _____

Release information from:

Name: _____
Address: _____
_____
Fax: _____

Disclose the information to:

Advanced Mobile Healthcare & Community Clinic
701 N. Goddard Rd 437 Cedar St
Goddard, Ks 67052 Kingman, Ks 67068
Fax: 316-794-2669 **Fax: 620-553-5029**

Requested medical information (Either check complete **OR** check only those that apply)
• Complete Medical Records, including any/all records received by other healthcare providers

- Clinic Notes
- Consultation Notes
- Disability/FMLA Forms
- Discharge Summary
- EEG, EKG, Stress Test
- Emergency Room Record
- Endoscopy
- History & Physical
- Immunizations
- Itemized Bill(s)
- Laboratory Reports
- Medications
- Operation Report(s)
- Pathology Reports
- Radiology Reports
- Other (specify):_____

NOTE: While Advanced Mobile Healthcare & Community Clinic makes every effort to protect the privacy of your medical information, please note that release of your medical information to the authorized person or organization could be the subject of re-disclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws.

- Records related to HIV status may not be released unless the individual has signed a separate release specific to HIV related information. 5 U.S.C. §19203-D.
- Psychotherapy notes may not be released unless the individual has signed a separate release specifying that such notes may be released. 45 CFR § 164.508 (b)(3)(ii).
- Drug or alcohol records may not be released unless authorization specifies the extent and nature of records to be released. 42 U.S.C 290dd-3; 42 U.S.C. 290ee-3; 42 CFR, Part 2.
- This authorization expires one year from the date of signature.

X_____ Date:_____
Signature of Patient/Parent/Guardian

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Patient Information

Last Name:	First Name:	Middle Initial:
Address:	City:	State/Zip:
Home Phone:	Birth date:	SS#:
Cell Phone:	Referred by:	
Gender: • M • F	Lives alone: • Yes • No	with:
Work Status: • Employed • Retired • Disabled • Unemployed • Other		
Marital Status: • Single • Married • Divorced • Separated • Widowed		
Ethnicity: • Hispanic • Non-hispanic	Race:	
Email (patient or relative)		

Health Insurance

Primary Insurance:	Group:	Policy/ID:
Name of Insured:	Birth date:	SS #:
Secondary Insurance:	Group:	Policy/ID:
Name of Insured:	Birth date:	SS #:

Emergency Contact Information

Name: Address:	Phone: Alt #:	Relationship:
Name: Address:	Phone: Alt #:	Relationship:

**The information on this form is complete and correct to the best of my knowledge.

I understand it is my responsibility to inform Advanced Mobile Healthcare & Community Clinic of any changes in the above information. Failure to do so may result in claims being denied. I understand that any unpaid claims will become my responsibility.

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MEDICAL HISTORY QUESTIONNAIRE

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible. Please use additional pages to write any information not included here you think is important.

Name: _____Birth date:_____ Date:_____
Person filling out form: _____ Relationship: _____

1. Current/Past Medical Problems: Example Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye problems, etc.

Current or Past Medical Problem	Year of diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

2. Past Surgeries: Example Gallbladder removed, Appendectomy, Hysterectomy with or without ovaries removed, Cataract surgery, Prostate surgery, Heart surgery, etc.

Past Surgery	Approximate Date of Surgery
1.	
2.	
3.	
4.	
5.	
6.	

3. Recent Hospitalizations: List reason for any recent hospitalizations in **past 2 years**.

Reason for Hospitalization	Name of Hospital	Date
1.		
2.		
3.		

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4. Recent Trips to Emergency Room: List reason for recent trips to the emergency room (ER) **in the past 2 years** and emergency room you used.

Reason for Trip to ER	Name of ER	Date
1.		
2.		

5. Recent Doctors: List all recent doctors, their specialty (e.g. Primary doctor, cardiologist, neurologist, etc.) and their phone number and fax number (if known).

Doctor Name	Specialty	Phone	Fax
1.			
2.			
3.			
4.			

6. Medical Allergies and reaction: Example rash, swelling, trouble breathing, etc.

Medicine Allergies	Reaction	Medicine Allergies	Reaction
1.		**2.**	
3.		**4.**	

7. Medications: Please list both prescription and over the counter medications (such as pain relievers, constipation medicine, heartburn medicine, vitamins, etc.). Give estimated frequency of use of as needed meds.

Medication and Strength (mg or mcg, etc.)	How Often Taken or As Needed
1.	
2.	
3.	
4.	
5.	
6.	

8. Local Pharmacy: _____ Phone #: _____
Mail Order Pharmacy: _____ Phone #:_____
Member ID #: _____ Fax #: _____

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9. Family History: List medical problems of close family members (example dementia, cancer and what type, heart disease, stroke, diabetes, hypertension, depression, etc.), if anyone has died, the age of death and the cause of death.

Family Member	Alive/Deceased	List Any Medical Problems and/or cause of death
Father		
Mother		

10. Social History:

Tobacco Use: Never Current Past Quit date_____
Type: • Cigarette • Cigar • Pipe • Chewing _____ppd _____ yr
Alcohol Use: • None • Rarely • 1-2 drinks/month • 1-2 drinks/week • 1-2 drinks/day
Was drinking too much alcohol ever a problem for you? • Yes • No
Illegal Drug Use: • Never • Current • Past Type _____ Quit date _____

Advance Directives: • Living Will • Durable Power of Attorney for Healthcare
Name and relationship:_____ • Do Not Resuscitate Form
Would you like information on Advanced Directives? • Yes • No
***If you have any of the above documents please have a copy of them made for the chart.**

11. Medicare Home Health Agency: • Yes • No

Name:	**Phone** #:
Nurse: • Yes • No	**Physical therapy:** • Yes • No
Speech Therapy: • Yes • No	**Occupational Therapy:** • Yes • No

The above information is correct to the best of my knowledge.

X_____ **Date:** _____
Signature of Patient/Parent/Guardian

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Statement of Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our statement of Financial Policy, which we require all of our patients to read, understand, and sign prior to any non-emergent treatment or care.
In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card prior to your initial visit.

Methods of Payment: We accept Cash, Checks, Visa, Discover and MasterCard. We offer payment plans and are happy to provide financial counsel, if requested.
When is Payment Due: Payment is due at the time services are rendered. To see how this affects your specific insurance situation, please discuss with the registration staff.

About Your Insurance Coverage:

- Medicare/Medicaid, as required, we will file claims with Medicare and/or Medicaid. You are responsible to pay all Medicare co-payments and for services not covered under the Medicare program. If you are covered by Medicaid, you are responsible for providing proof of current coverage and any applicable spend-down amount.
- Commercial/indemnity insurance, your policy is a contract between you and your insurance company. Since we are not a party to that contract, **your account balance is your responsibility whether your insurance pays or not.** As a courtesy, we will file a claim on your behalf. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.
- Managed Care plan (HMO, POS, PPO), you are responsible for paying any **copayments, deductibles, and non-covered services** at the time services are rendered. **It is the patient's responsibility to verify a provider's participation in their health plan prior to making an appointment.** If your plan requires a referral for any service beyond your Primary Care Provider, you must contact our office. This will allow you to obtain the necessary information and authorization for your visit. Please understand that if you fail to do so, the visit may NOT be authorized by your insurance carrier. We must comply with your insurance company's rules and will NOT issue a retroactive referral for services already provided by another provider.
- Self-Pay or Self-Filing patients who do have insurance coverage, who are unable to provide us with valid insurance information, or who wish to file their own insurance claims are responsible to pay **100% of charges** at the time services are rendered.

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About our Staff:

Our staff has been trained to understand many insurance company policies, but they DO NOT have **all** the answers about your specific benefits. Please contact your employer for a copy of your *Benefits Guidebook*, or call your insurance company, should you need detailed information about your coverage.

Past Due Account Balances:

If your account balance becomes past due, appropriate action will be taken to collect the amount due. If you have issues that prevent you from paying the full balance due, please contact our Business Office so we can help find a solution. If your account is in Collection, you may be dismissed from all Advanced Mobile Healthcare & Community Clinic, LLC practices and no longer eligible for services until your balance is paid in full. Interest may be accrued if payments not made in a timely manner.

Returned Checks:

The fee for all checks returned for insufficient funds is $50.00. This fee will be automatically charged to your account when your check is returned from the bank.

Thank you for reading and understanding our Statement of Financial Policy. Please let our Practice or Business Office know, if you have any questions or concerns.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY I UNDERSTAND AND AGREE TO THE POLICY

Print Patient's Name_____ Date_____

Signature _____ Date_____

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CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care at Advanced Mobile Healthcare & Community Clinic (AMHCC) that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the provider (and/or designated assistant) and carried out by members of AMHCC's staff and personnel. I also authorize access to my medication history electronically from the national Surescripts database in order to streamline data entry, increase accuracy and enable my healthcare provider to make better informed decisions.

ASSIGNMENT OF BENEFITS

In consideration of these medical services, I hereby assign, transfer and set over to AMHCC all my rights, title and interest to medical reimbursement benefits under my insurance policy (s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to AMHCC, with regard to my treatment and care with this AMHCC practice.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize AMHCC to release medical information or copies from my medical record within a reasonable time frame to insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers' insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time.

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I have received and have been presented with the opportunity to review the AMHCC Financial Policy. I understand and agree to the policy. **I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient to AMHCC**. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. Any assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver of AMHCC's right to require payment directly from the undersigned. AMHCC expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several. All deductibles and co-pays are due at the time of service. We accept cash, checks, or Visa/Master cards.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below you acknowledge receipt and opportunity to review AMHCC Healthcare Privacy Policy Notice and consent to sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment and Payment agreement.

I understand and agree to the above statements.

Patient name	Birth Date	X **Signature** of Patient/Parent/Guardian	Date

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Authorization to Leave Message

In completing and signing this form, I authorize that Advanced Mobile Healthcare & Community Clinic may leave a message containing medical information as follows:

- On my home voice mail/answering machine. • Yes • No • N/A
- On my cell phone voice mail #_____. • Yes • No • N/A

Designated Personal Representatives

In the space below, if so desired, please indicate any personal representatives(s) (i.e. any family member, friend, or individual) who is permitted to receive or know personal health information concerning your health care for a period of 24 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact AMHCC in writing and request the change.

• I designate personal representatives as follows:

_____

Name Relationship Phone number

_____

Name Relationship Phone number

_____

Name Relationship Phone number

If you would like to change any of the information on this form, prior to the end of the time period stated above, you must contact AMHCC in writing and request the change. This form must be up-to-date, signed and on file in your chart prior to any medical information being left on answering machines or with individuals you designate.

_____ _____ X_____ _____

Patient name Birth date Signature of Patient/Parent/Guardian Date