K+STAT Adult Medical History Form

Name (Last, First Name MI):	Today's Date:
	Date of Birth:

Present Health Concerns:

Preferred Pharmacy:

Medications: Prescription, non-prescription medicines, vitamins, home remedies, birth control pills, herbs: ☐ **None**

Medication	Dose	Times per Day	Medication	Dose	Times per Day

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis) ☐ **NEGATIVE MEDICAL HISTORY**

☐ Asthma	☐ Eye Contacts/ Glasses ☐ Vision Problems Details:	☐ High Blood Pressure
☐ Blood Clots	☐ Hearing Loss	☐ Migraine Headaches
☐ Cancer Type: Date:	☐ Heart Problems ☐ Valvular (mitral/aortic) ☐ Rhythm (a-fib) ☐ Blockage (heart attack)	☐ Stroke ☐ Thyroid
☐ Concussion ☐ Depression		☐ Other
☐ Anxiety	☐ Covid 19-Date:	
☐ Diabetes	☐ High Cholesterol	

Surgical History: (please list all prior operations and dates) ☐ **NO SURGERY**

Operation	Date	Operation	Date

Women's Gynecological: Date of last menstrual period:

Social History:

Occupation:	Marital Status (circle): Sgl / Mar / Wid / Div
Who lives at home with you:	Number of Children:
Caffeine Intake: ☐ Never ☐ Occasional ☐ Daily	Alcohol: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Quit Date _____ ☐ Amount per week: _____
Tobacco: ☐ Never ☐ Vape ☐ Smokeless Tobacco (Chew) ☐ Smoker	Drug Use: ☐ Never ☐ Occasional ☐ Daily

Allergies or Reactions to Medicines/Foods/Other Agents: ☐ **CHECK IN NO ALLERGIES**

MEDICATION	Reaction or Side Effect

VACCINES & IMMUNIZATIONS:

☐ TetanusTd:_____	☐ Tetanus/Pertussis(Tdap):_____	☐ Influenza_____	☐ Covid _____

PLEASE COMPLETE ALL AREAS OF FORM AS THIS PROTECTS YOUR SAFETY AND IS REQUIRED FOR PROPER INSURANCE REMIMBURSEMENT; IF UNKNOWN LIST 'UNK'

K+STAT URGENT CARE Patient Registration Form

Patient Name:			Date of Birth: / /
Address:			SSN: - -
			Sex: Male Female
City, State, Zip:			Marital Status: (circle one) SGL / MAR / WID / DIV
Home Phone:	Cell Phone:	Work Phone:	
Email:			By providing your email, you consent for K+STAT to securely send you information at the email address provided.
Language: □ English □ Spanish □ Other			

Race: □ American Indian □ Asian □ Black or African American □ Other
□ Native Hawaiian or Other Pacific Islander □ White □ Decline to Answer

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Decline to Answer

Emergency Contact:

Name:	Relationship:
Phone:	Patient at K+STAT: Y or N

Responsible Party Information: (This person is responsible for patient insurance and billing)

Name:	DOB:	Relationship:
Address:		Patient at K+STAT: Y or N
City, State, Zip		Phone:

Insurance Information:

Insurance Company:	Policy#:	Group #:
Card Holder Name	Card Holder DOB:	Relationship:

May we leave medical details / results on your answering machine? (circle) Y / N		
May we leave medical details / results with someone other than yourself? (circle) Y / N		
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

Hipaa Consent of Privacy

I acknowledge that I have been given the opportunity to read and review the K+STAT Urgent Care Notice of Privacy Practice. I understand that if I have question after I read it, I may contact the K+STAT Privacy Officer at (785)-587-4101 for answers to my questions, or to obtain more information related to the security of my medical records. I understand that if I wish to restrict access to my medical information, I have the right to detail that request to K+STAT Urgent Care. I also understand that by restricting access to my insurance company, I may become financially responsible for my account balance. By signing this form, I consent to the use of and disclosure of Protected Health Information for treatment and payment of healthcare operations.

Authorization and Assignment of Benefits for K+STAT Urgent Care

I authorize K+STAT Urgent Care to release any medical information that is necessary to request claim reimbursement from the insurance companies. I also assign the claim payment(s) to be made payable to K+STAT Urgent Care. A copy of this authorization and assignment shall be as valid as the original. Services not paid for when rendered are due upon receipt of a statement, unless other arrangements have been made. Payment is expected by return mail. Thank You.

Patient or Legal Guardian Signature: _____ Date: _____

K+STAT URGENT CARE
930 Hayes Dr, Suite B, Manhattan, KS 66502
Phone: 785-565-0016 Fax: 785-565-0003

Financial Policy

This is an agreement between K+STAT Urgent Care and you, the patient named on this form.
Printed patient name: _____ **DOB:** _____

The patient and or guarantor is financially responsible for services rendered.

Self-Pay: Patients who do not carry health insurance coverage are self-pay. This means that you are required to pay for services in full at the time of your visit. We offer a 20% cash discount.

Lab: We outsource some of our lab work to Quest Diagnostics and Lab Corp. You will receive an additional bill.

Waiver of Physical: A physical is a service that is usually performed by a primary care physician. It is often not paid by insurance companies when performed in an urgent care setting. Anyone who wishes to receive a physical must accept financial responsibility. Payment is due at the time of service.

Insurance: At present, K+STAT Urgent Care is contracted with several commercial and non-commercial insurances. Please contact your insurance provider to verify coverage at our office. If your insurance requires a referral and/or preauthorization, you are responsible for obtaining it prior to your appointment.

AUTO-insurance: Patient is responsible for filing claim with auto insurance before visit. Patient must have a claim number or will be considered self-pay.

Out-of-Pocket Expenses: Out-of-Pocket expenses are the responsibility of the patient and are based on the individual policy. Payments are due with-in 30 days of being processed by insurance or finance charges will be applied. In cases where payment in full is not possible a payment plan can be made. The finance charge will be computed at the rate of 1.5% per month or an annual percentage rate of 18%.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect any debt, including turning your account over to a collection agency and reporting to the credit bureau. A service charge will be assessed to your account for this process.

Returned Checks: Stonecreek Family Physicians, LLP will be happy to accept your check as a form of payment. In the unlikely event that your check is returned unpaid, you understand and agree that your check will be collected electronically or redeposited by paper draft. You understand and agree that we will electronically collect the maximum returned check processing charge allowable by state law.

Workers' compensation: We require you to notify us at the time of visit that this is due to a work-related situation. Failure to do so will make you financially responsible for this bill. K+STAT will bill workers compensation companies we are contracted with. Any other claims must be paid at the time of service. Patient is responsible for filing injury report with employer prior to visit.

Waiver of Confidentiality: You understand if your account is submitted to a collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at Stonecreek Family Physicians, LLP will become a matter of record.

Children of Divorced Parents: The parent, or responsible party, accompanying a child (ren) for care is responsible for payment at the time of service. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Account statements for child(ren) will be sent to the address where the child resides most of the time or the parent designated in the divorce decree as financially responsible for the child(ren)'s expenses.

PRINTED RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____/_____/_____

Revised: March 2021