K.C. PULMONARY ASSOCIATES

PULMONDARY DISEASES, CRITICAL CARE & SLEEP MEDICINE

AMAN U. KHAN, M.D., F.C.C.P. SABATO SISILLO, M.D., F.C.C.P. GEORGE REISZ, M.D., F.C.C.P.

PATIENT'S NAME: _____

ADDRESS _____

CITY, STATE, ZIP CODE: _____

TELEPHONE: HOME _____ CELL: _____ WORK: _____
BIRTH DATE: _____AGE: _____SEX: _____SOCIAL SECURUTY #_____
MARITAL STATUS: S M D W
PATIENT EMPLOYEDBY: _____OCCUPATION: _____
BUSINESS ADDRESS _____

PERSON WHO REFERRED YOU_____

Name of PHYSICIAN: _____

PHONE _____ ADDRESS: _____

PRIMARY INSURANCE _____EFFECTIVE DATE_____

POLICY # _____GROUP# _____

PRIMARY INSURED'S NAME_____ BIRTH DATE: _____

RELATIONSHIP TO INSURED_____

SECONDARYINSURANCE_____EFFECTIVEDATE_____

POLICY#_____GROUP#_____

SECONDARY INSURED'S NAME: _____BIRTH DATE:_____

ASSINGMENT AND RELEASE

I authorize KC Pulmonary Associates to release information about me concerning advice; care and treatmentprovidedmetomyinsurancecompany forthepurposeoffilinganinsuranceclaim. Iauthorize paymentof insurancebenefitstobemadedirectlytoKCPulmonaryAssociates. IunderstandthatI am financiallyresponsibleforpaymentofanydeductible,co-insuranceoranybalancenotcoveredbymy insurance.

Furthermore,IauthorizeKCPulmonaryAssociatestoreleasemyrecordstomyprimaryphysicianfor coordination ofmy care unless specified otherwise.

DATE: _____ SIGNATURE_____

8919 Parallel Parkway, Suite 203 Kansas City, KS 66112 (913) 268-5400 Fax (913) 268-5410

PATIENT CONTACT INFORMATION

The HIPAA privacy rule provides the patient with the right to request confidential communication or that communication of Protected Health Information is made by alternative means, such as sending to the correspondence to the individual's office instead of to the individual's· home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
CHECK ALL THAT APPLY:

Home telephone: _____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only

Cell Phone_____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only

Work telephone: _____

- ○ OK to leave message with detailed information
- ○ Leave message with call-back number only·

Written communication

- ○ OK to mail to Home Address: _____
- ○ OK to mail to my Work/Office Address_____
- ○ OK to Fax to this number_____
- ○ OK to Email to this Address_____

Other

- ○ OK to Share the information with the Following person (s):
- ○ _____
- ○ _____

Person (not living with you) to contact if unable to reach you directly:

Name:_____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____