THE UNIVERSITY OF KANSAS HEALTH SYSTEM
Topeka High School Campus Care

Appointment date: ___ / ___ / _____

Patient Registration Form

DEMOGRAPHICS

Name: (First, Middle Initial, Last) _____ Date of birth: ___ / ___ / _____

Address: _____

Phone numbers: Home: _____ Work: _____ Mobile: _____

Email address: _____ **Employer:** _____

Occupation: _____ **For students, what grade in school?** _____ **Sex:** ☐ Male ☐ Female

Gender identity: ☐ Male ☐ Female ☐ Non-Binary, Third Gender ☐ Transgender Female/Male-to-Female ☐ Transgender Male/Female-to-Male ☐ Other ☐ Choose not to disclose

Pronouns: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ decline to answer ☐ other: _____

Ethnic group: ☐ Hispanic, Latino, or Spanish origin ☐ Non Hispanic, Latino, or Spanish origin ☐ Decline

Primary care provider or pediatrician name: _____

EMERGENCY CONTACT

Name (First, MI, Last): _____ Date of birth: ___ / ___ / _____

Phone number: _____ Employer: _____

Relationship: _____

COMPLETE THIS SECTION IF PATIENT IS AGE 18 OR OLDER

Legal guardian

Do you have a court appointed legal guardian? ☐ Yes ☐ No

If yes, please list name of guardian:

Name: _____

Address: _____

Phone number: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Life Partner ☐ Widowed ☐ Decline

Do you have an advanced directive or living will? ☐ Yes ☐ No

(If yes, we would like a copy for your chart)

COMPLETE THIS SECTION IF PATIENT IS AGE 17 OR YOUNGER

Please list name(s) of parent(s)/guardian(s):

Name: _____
Address: _____
Phone number: _____

Name: _____
Address: _____
Phone number: _____

PRIMARY HEALTH INSURANCE

Policy holder's information

Name (First, MI, Last): _____ Date of birth: ___ / ___ / _____
Relationship to patient: _____
Address: _____
Phone number: _____ Employer: _____

Insurance company: _____
Group number: _____ Policy number: _____

SECONDARY HEALTH INSURANCE

☐ I do not have secondary insurance

Policy holder's information

Name (First, MI, Last): _____ Date of birth: ___ / ___ / _____
Relationship to patient: _____
Address: _____
Phone number: _____ Employer: _____

Insurance company: _____
Group number: _____ Policy number: _____

COMMUNICATION

Do you allow us to leave detailed messages regarding appointments or test and lab results?

Voicemail message: ☐ Yes ☐ No Email message: ☐ Yes ☐ No

How did you hear about this clinic? _____

Please provide any additional comments and notes here:

_____
_____
_____

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160 **CONSENT FOR MEDICAL TREATMENT**	**Do not write in this box** DT5146 AMB Consent for Tx	**Name:** _____ **DOB:** _____ **MRN:** _____

1. **MEDICAL CONSENT:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations. I voluntarily consent to medical care, including routine diagnostic procedures, surgery and medical treatment by the medical staff at **The University of Kansas Hospital** and **The University of Kansas Physicians** or their assistants or designees as is necessary in their judgment for the patient listed above.

2. **ACADEMIC MEDICAL CENTER:** I understand that as an Academic Medical Center and teaching facility, patients are seen by staff physicians, resident physicians and other healthcare students and observers.

3. **RADIATION EXPOSURE:** I am aware that some imaging tests and procedures, beneficial to my care, may expose me to radiation. I understand my radiation exposure will be kept as low as possible. Any specific risk associated with the test or procedure or radiation will be explained to me by my physician. I understand I have the right to refuse the test or procedure.

4. **CLINICAL PHOTOGRAPHY AND VIDEO MONITORING:** The use of clinical photography and video monitoring in some circumstances may be considered routine to patient care. Except in an emergency, I understand I:
   - Will be informed prior to the clinical photography or video monitoring of the use and purpose of the picture or video;
   - Have the right to refuse clinical photography or video monitoring;
   - Have the right to withdraw consent for future clinical photography or video monitoring at any time; and
   - Have the right to request an amendment of the medical record to remove clinical photography or video monitoring from the record by contacting the Privacy Officer.

   Patient identification photos may also be taken to insure patient identity and facilitate medical care. Photos will be updated when my physical condition changes significantly.

5. **SCIENTIFIC STUDY AND DISPOSAL OF HUMAN TISSUE AND BODY FLUIDS:** I consent that The University of Kansas Hospital and The University of Kansas Physicians may retain, study, use and/or dispose of any blood, fluid, specimen or tissues which may be removed from me during my visit.

6. **BLOOD/BODY FLUID EXPOSURE:** I understand and consent to testing for Human Immunodeficiency Virus (HIV), Hepatitis, and/or other blood-borne illnesses if an individual is exposed to my blood or other bodily fluids. I understand law permits this testing, and should such testing occur, I will not be billed for it.

7. **RELEASE OF INFORMATION:** I understand the confidentiality of all medical records and information will be protected to the full extent of the law and will only be disclosed with my prior written authorization, unless the disclosure is otherwise permitted or required by applicable law. Please refer to the, The University of Kansas Medical Center Notice of Privacy Practices which governs release of information.

8. **COMMUNICATIONS CONSENT:** By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from UKHS and its agents, including those that may be made using an automatic or computer-assisted telephone dialing system, text messaging and/or artificial or prerecorded voice message. These parties may use this information to contact me for any purpose related to my care or UKHS' operations, including but not limited to, appointments, health care reminders, wellness checkups, pre-registration, and pre-operative instructions. I understand that depending on my phone plan I could be charged for these calls or text messages.

9. **PERSONAL VALUABLES:** I understand that The University of Kansas Hospital and The University of Kansas Physicians are not responsible for the loss or damage of any personal items (i.e. money, credit cards, jewelry, clothing, etc.) I wish to keep with me and that The University of Kansas Hospital and The University of Kansas Physicians will not replace <u>any</u> lost or damaged goods.

10. **IMPLANTED MEDICAL DEVICES:** I understand The University of Kansas Hospital and The University of Kansas Physicians, when required, will release my social security number to the manufacturer of any medical device implanted or prescribed to me so that I may be notified in the event of a recall.

My signature below acknowledges that I have read and understand this document and am authorized to sign.

_____
Signature of Patient or Surrogate Decision-maker*

_____
Printed Name of Surrogate Decision-maker*

*Relationship to Patient: ☐ Parent ☐ Legal Guardian
☐ Durable Power of Attorney (DPOA)
☐ Other/Relationship: _____

_____ _____
Today's Date Time

Interpreter Required: ☐ YES ☐ NO

Mode of Interpretation: ☐ Sight Translated ☐ Interpreted

_____
Signature of Interpreter

_____
Interpreter's Printed Name

_____ _____
Today's Date Time

*Authorization must be signed by the patient, or if applicable, by an appropriate surrogate decision-maker

CONSENT FOR MEDICAL TREATMENT

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160 **CONSENTIMIENTO PARA EL TRATAMIENTO MÉDICO**	**No escriba en este cuadro** DT5146 AMB Consent for Tx	**Nombre:** _____ **F. de N.:** _____ **Registro médico n.º**_____

1. **CONSENTIMIENTO MÉDICO:** Tengo plena conciencia de que la práctica de la medicina y la cirugía no es una ciencia exacta y reconozco que no se me ha dado ninguna garantía en relación con el resultado de los tratamientos o exámenes. Doy mi consentimiento de manera voluntaria para recibir atención médica, inclusive procedimientos rutinarios de diagnóstico, cirugía y tratamiento médico por parte del personal médico en **The University of Kansas Hospital** y **The University of Kansas Physicians** o sus asistentes o personas designadas de la manera que sea necesaria a su criterio para el paciente indicado anteriormente.
2. **CENTRO MÉDICO ACADÉMICO:** Entiendo que como centro médico académico y centro de enseñanza, los pacientes son atendidos por parte de médicos del personal, médicos residentes y otros estudiantes y observadores de la atención a la salud.
3. **EXPOSICIÓN A RADIACIÓN:** Estoy enterado de que algunas pruebas y procedimientos de imaginología, que son beneficiosos para mi salud, pueden exponerme a radiación. Entiendo que la exposición a la radiación se mantendrá lo más baja posible. Mi médico me explicará los riesgos específicos asociados con la prueba, el procedimiento o la radiación. Entiendo que tengo derecho a negarme a la prueba o procedimiento.
4. **FOTOGRAFÍA CLÍNICA Y CONTROL MEDIANTE VIDEO:** El uso de la fotografía clínica y el control mediante video en algunas circunstancias se puede considerar atención de rutina. Excepto en caso de emergencia, entiendo que:

- Antes de tomar fotografías clínicas o de realizar un control mediante video, me informarán acerca del uso y fin de la fotografía o video.
- Tengo el derecho a negarme a las fotografías clínicas o el control mediante video.
- Tengo el derecho de retirar el consentimiento para futuras fotografías clínicas o control mediante video en cualquier momento.
- Tengo el derecho de solicitar una modificación de los registros médicos para eliminar las fotografías clínicas o el control mediante video de los registros comunicándome con el Funcionario de Privacidad.
  También se pueden tomar fotografías que identifiquen al paciente para asegurar la identidad del paciente y para facilitar la atención médica. Se actualizarán las fotos cuando mi estado físico cambie significativamente.

5. **ESTUDIO CIENTÍFICO Y ELIMINACIÓN DE TEJIDOS HUMANOS Y FLUIDOS CORPORALES:** Doy mi consentimiento para que The University of Kansas Hospital y The University of Kansas Physicians guarden, estudien, usen y/o eliminen la sangre, los fluidos, las muestras o tejidos que me extraigan durante las visitas.
6. **EXPOSICIÓN A SANGRE/FLUIDOS CORPORALES:** Entiendo y doy mi consentimiento para que me realicen una prueba de detección del virus de la inmunodeficiencia adquirida (VIH), hepatitis y/u otras enfermedades que se transmitan a través de la sangre si una persona se ve expuesta a mi sangre u otros fluidos corporales. Entiendo que la ley permite estas pruebas y si hubiera que hacerlas, no me cobrarán por realizarlas.
7. **DIVULGACIÓN DE LA INFORMACIÓN:** Entiendo que se protegerá la confidencialidad de todos los registros médicos en la medida que lo permita la ley. El Aviso de Prácticas de Privacidad de The University of Kansas Medical Center regula la divulgación de la información. Autorizo a The University of Kansas Hospital y The University of Kansas Physicians a que divulguen información médica a cualquier compañía de seguros o agencia de autorización con el fin de obtener el pago. También autorizo la divulgación de información médica a mi médico de atención primaria o a los médicos que realicen derivaciones o a otros proveedores de atención médica involucrados en los servicios de atención a los pacientes. La información médica puede incluir registros relativos a la atención de salud mental, enfermedades contagiosas, VIH/SIDA y/o tratamiento para abuso de alcohol/drogas. Autorizo la divulgación de estos registros.
8. **OBJETOS PERSONALES DE VALOR:** Entiendo que The University of Kansas Hospital y The University of Kansas Physicians no son responsables por la pérdida o daño de objetos personales (es decir, dinero, tarjetas de crédito, joyas, ropa, etc.) que desee guardar conmigo y que The University of Kansas Hospital y The University of Kansas Physicians no reemplazarán ningún objeto dañado o perdido.
9. **DISPOSITIVOS MÉDICOS IMPLANTADOS:** Entiendo que The University of Kansas Hospital y The University of Kansas Physicians, cuando sea necesario, divulgarán mi número de seguro social al fabricante de cualquier dispositivo médico que me hayan implantado o recetado para que me notifiquen en caso de que retiren el producto del mercado.

A través de mi firma reconozco que he leído y entendido este documento y estoy autorizado a firmar.

_____
Firma del paciente o sustituto de toma de decisiones*

_____
Nombre en imprenta del sustituto de toma de decisiones

*Relación con el paciente: ☐ Padre ☐ Tutor legal
☐ Poder duradero (DPOA, por su sigla en inglés)

☐ Otro/Relación: _____

_____ _____
Fecha de hoy Hora

Intérprete requerido: ☐ SÍ ☐ NO

Modo de interpretación
☐ Traducido a la vista ☐ Interpretado

_____
Firma del intérprete

_____
Nombre en imprenta del intérprete

_____ _____
Fecha de hoy Hora

*La autorización la debe firmar el paciente, o si corresponde, un sustituto para tomar decisiones adecuado.

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160	**Do not write in this box**  D T 4 1 5 1	**Name:** _____ **DOB:** _____ **MRN:** _____

I have been offered the Notice of Privacy Practices for The University of Kansas Health System Organized Health Care Arrangement

Me han ofrecido el Aviso sobre las Normas de Privacidad del The University of Kansas Health System Organized Health Care Arrangement

Мне было предложено "Заявление о правилах конфиденциальности" **Медицинского центра Канзасского университета** Обеспечение организованных медицинских услуг

के यू चिकित्सकीय केन्द्र संगठित स्वास्थ्य सेवा व्यवस्था (KU Medical Center Organized Health Care Arrangement)-मा गोपनीयतासम्बन्धी प्रयोगमा ल्याइने प्रक्रिया बारे मलाई जानकारी उपलब्ध गराइयो

_____ _____

Signature (*Firma*) (*Подпись)* हस्ताक्षर

_____ _____

Date (*Fecha*) *(Дата)* तारिख

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160 **FINANCIAL POLICY**	**Do not write in this box** DT5149 AMB Financial Policy	**Name:**_____ **DOB:**_____ **MRN:**_____

Thank you for selecting The University of Kansas Health System as the health care providers for you and your family. We want all of our patients to understand our financial policies regarding payments, insurance filing and collection.

Whenever you change address, telephone number, family status, insurance, etc., please call registration or inform us at check in.

We require a copy of your insurance cards. We need your insurance information for filing claims. If you cannot provide a current insurance card, you will be responsible for your fees at the time of service. We will also file an insurance claim if the insurance card is provided. After the insurance company has made payment, you will be refunded any monies due.

All co-pays, deductibles, authorizations, and/or referrals are due at the time of service. If you have an HMO insurance carrier, it is your responsibility to obtain an insurance referral authorization from your primary care physician. This referral should specify The University of Kansas Health System, The University of Kansas Hospital and/or The University of Kansas Physicians, name of the specific provider you will see, and the time range the referral will cover.

If either The University of Kansas Hospital or The University of Kansas Physicians does not have a contract with your insurance company, your visit may be considered out- of-network. This may increase your out-of-pocket cost or result in denied services. It is possible that you will be in network for The University of Kansas Hospital and not for your physician.

If you do not have health insurance, or you are out-of-network with your insurance, you will be responsible for paying for all services rendered. By signing this document, you agree to pay The University of Kansas Health System the amount billed for treatment at the time of the visit. If you have no insurance, you may be eligible for financial assistance.

Monthly statements will be mailed from The University of Kansas Health System. Please review your statements for accuracy and report any questions to our billing office. Accounts will be placed with a collection agency after 90 days of no activity. If you are on a payment plan and miss your monthly payment, the account may be turned over to collections.

Patients who fail to come for their appointments and do not notify the clinic in advance prevent other patients from being seen in a timely manner. Please provide at least 24-hours' notice in advance if you need to cancel or reschedule your appointments by calling your clinic directly or by calling the Health Resource Center at (913) 588-1227. Patients who repeatedly fail to attend or cancel their scheduled appointments may be subject to dismissal by either the individual department affected or by other departments within the Health System.

AUTHORIZATION TO BE CONTACTED: I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by The University of Kansas Health System or any entity to which The University of Kansas Health System assigns my account. I also consent to the use of any updated or additional contact information that I may provide by The University of Kansas Health System or any entity to which The University of Kansas Health System assigns my account. I consent to the use of technology, including an automatic telephone dialing system and/or artificial prerecorded voice message, in contacting me regarding any matter related to my account. I understand these calls are for debt collection purposes, and not advertisements or for telemarketing purposes. I understand that I can revoke this consent for automated calling at any time by contacting Customer Service for The University of Kansas Health System at 913 588-5820 (Toll free: 1-877-287-6268).

AUTHORIZATION FOR RELEASE OF BENEFIT INFORMATION
I authorize the release of any and all information requested by The University of Kansas Heath System in accordance with my applications for state benefits, federal benefits or other related benefits. My signature on this release is intended to provide for the free exchange of information between all such agencies and The University of Kansas Health System.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INSURANCE REPRESENTATION
I assign all rights to benefits, insurance proceeds or other payments or judgments that I may be entitled for hospital -based physician services, outpatient-based services, and office-based services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier. I authorize The University of Kansas Health System or an organization providing the services on its behalf to act as my representative to request reconsideration by my managed care plan or utilization review committee for coverage or grievance review.

Please sign back of form

THE UNIVERSITY OF KANSAS HEALTH SYSTEM 4000 Cambridge Street Kansas City, Kansas 66160 **FINANCIAL POLICY**	**Do not write in this box**	**Name:**_____ **DOB:**_____ **MRN:**_____

My signature below acknowledges that I have read and understand this document and am authorized to sign.

_____
Signature of Patient or Surrogate Decision-maker*

_____
Printed Name of Surrogate Decision-maker*

*Relationship to Patient: ☐ Parent ☐ Legal Guardian
☐ Durable Power of Attorney (DPOA)
☐ Spouse

_____
Today's Date

Interpreter Required: ☐ YES ☐ NO
If yes,
Mode of Interpretation:
☐ Sight Translated ☐ Interpreted

_____
Signature of Interpreter

_____
Interpreter's Printed Name

_____ _____
Today's Date Time

*Authorization must be signed by the patient, or if applicable, by an appropriate surrogate decision-maker.