Kansas City Psychiatric Group

PATIENT REGISTRATION

(Please Print)

Date _____ Clinician _____

Name _____ Social Security # _____
(Last) (First) (MI)

Date of Birth:_____Age:_____ Sex: ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Email Address_____

☐ Home Phone (_____) _____ ☐ Work Phone (_____) _____

☐ Mobile/Alt. Phone (_____) _____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Name of Employer (or School) _____ Grade _____

Student Status: Full-time _____ Emergency Contact name and ph. #: _____
Part-time_____

RESPONSIBLE PARTY

Responsible Party _____ Relationship to Patient _____
(Last) (First) (MI)

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Social Security # _____ Place of Employment _____

If other family members are seen in this office, please list: _____

***** AT THIS TIME A COPY OF YOUR CURRENT INSURANCE CARD AND PHOTO ID IS REQUESTED *****
ALTHOUGH WE TAKE A COPY OF YOUR INSURANCE CARD, WE DO REQUIRE THE FOLLOWING INFORMATION TO BE COMPLETED.

Primary Insurance Company:

Name: _____

Policy # _____ Group # _____

Subscriber Name: _____

DOB _____ SSN _____

Employer: _____

Secondary Insurance Company:

Name: _____

Policy #: _____ Group #:_____

Subscriber Name: _____

DOB: _____ SSN: _____

Employer: _____

Assignment of Insurance Benefits/Release of Medical Information

I authorize Kansas City Psychiatric Group to release any medical information which may be requested to process claims for payment of medical services through an insurance carrier, prepaid medical plan or a government agency.

I request that payment be made to Kansas City Psychiatric Group for any bills for service rendered to me by my doctor.

I understand that I am financially responsible to my doctor for any balance not covered by this authorization. I understand that insurance filing is done as a courtesy for the patient and my doctor takes no responsibility for denial or delay of payment.

_____

Responsible Party's Signature | Printed Name of Signee | Patient Name | Date

Informed Consent for Treatment

I give my consent for services for myself or my child/legal dependent with Kansas City Psychiatric Group and associated members of the professional staff to include evaluation, psychotherapy, medication management, testing (if indicated) and involvement in the treatment planning process. I may at any time decline specific recommendations.

***We reserve the right to discharge any patient from this practice at any time for failure to comply with treatment recommendations or office policy responsibilities. We will suggest referral options in this event.**

_____

Responsible Party's Signature | Printed Name of Signee | Patient Name | Date

Consent to Release Information to Primary Care Physician

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

I, Do_____/Do Not _____, authorize Kansas City Psychiatric Group to release information related to my evaluation and treatment to:

Primary Care Physician: _____ Phone: _____

Address:

_____

(Street) | (City) | (State) | (Zip)

_____

Responsible Party's Signature | Printed Name of Signee | Patient Name | Date

If you would like to release medical information to another physician please request a separate release of information form from the receptionist.

Consent for E-Prescribing & Medication History

I understand that as a part of my electronic health record, Kansas City Psychiatric Group may transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Kansas City Psychiatric Group will obtain the history of all my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

_____

Responsible Party's Signature | Printed Name of Signee | Patient Name | Date

Kansas City Psychiatric Group

Kansas City Psychiatric Group has adopted a policy, in order to comply with the HIPAA Privacy Regulation, requiring physicians and staff to obtain authorization from the patient to leave detailed messages for that patient. This policy is to protect the patient's privacy. If there is not a signed consent on file, physicians and staff will only leave a name and telephone number on an answering machine, voicemail, or with a live person answering the phone.

I have been given a copy of the Notice of Privacy Practices prior to signing this consent. Kansas City Psychiatric Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kansas City Psychiatric Group 4500 College Blvd., Suite 304, Overland Park, Kansas 66211. It is also available online at www.kcpsych.com.

By completing the consent below, you are allowing Kansas City Psychiatric Group physicians and its staff to leave a message on an answering machine, voicemail, or with a specified individual. You may also specify what information may be left and with whom by noting the information at the bottom of this form.

I give my consent to Kansas City Psychiatric Group physicians and staff to leave a message regarding scheduling, treatment, lab results or other information as necessary. (Check all that apply).

It is permissible to contact me at the telephone locations checked below:

- ☐ Home Telephone Number: (____) _____ - _____
- ☐ Work Telephone Number: (____) _____ - _____ ext. _____
- ☐ Mobile Telephone Number: (____) _____ - _____

It is permissible to leave voice messages at the telephone locations checked below:

- ☐ Home Telephone Number
- ☐ Work Telephone Number
- ☐ Mobile Telephone Number

My preference for ***automated appointment reminders*** is (please check one):

- ☐ Voice call to Home Telephone Number
- ☐ Voice call to Mobile Telephone Number
- ☐ Text Reminder to Mobile Telephone Number
- ☐ None-I do not wish to get automated reminders.

_____

Signature of Patient or Legal Guardian Date

_____

Print Patient Name Print Name of Legal Guardian

Kansas City Psychiatric Group

Please read the following information carefully

Our office will do whatever we can to assist you. If you have any questions or problems, please do not hesitate to contact our billing office.

All patients must complete the patient information form and sign this policy agreement in order to be seen in this office.

I have read and agree to the below office policies.

Signature: _____ **Date:** _____

Dear Patients and Families,

We thank you for choosing KCPG and look forward to working with you. We strive to provide the very best care and in order to do so we would like to take this opportunity to acquaint you with our office policies. Please take a few moments to read over the following information. **In addition, we suggest you review your health insurance policy and familiarize yourself with the coverage and limitations that it provides.**

APPOINTMENTS

We ask that you try to schedule your appointments as soon as possible--hopefully after each office visit--as routine follow-up time slots are typically booked for several weeks into the future at any given point in time. If you are unable to keep your appointment, please notify our office one working day (**24 hours**) in advance, to avoid being billed for the time. **A missed appointment will be billed at a rate determined by your physician and charged to your account. As insurance does not pay for missed appointments, the patient/guarantor is responsible. Please note that two consecutive missed appointments may result in being discharged from care.** We will make an attempt to contact you to confirm each appointment two working days ahead of time. This call is a **courtesy,** and our failure to reach you will not relieve you of your responsibility for any missed appointment charges**.**

PRESCRIPTIONS

If you are on medication, please request any needed renewal prescriptions at the time of your appointment. In general, you will be provided enough refills to last until your next expected appointment. If you do require refills between appointments, **please notify your pharmacy and have them send a refill request to our office during regular phone hours 9AM to 4PM Monday through Friday. Prescriptions for controlled substances cannot be called in and will require a written prescription**. **Please notify our office of a need for a prescription three business days in advance. Failure to make follow-up appointments as directed by the doctor, or missing a scheduled appointment, may result in a prescription fee.** Prescriptions may be picked up during business hours, Monday through Friday 9:00 am to 5:00 pm.

LETTERS AND FORM COMPLETION

We require a minimum of 48 hours for all letters and form completion. Any information that you would like forwarded to another provider, school, attorney, employer etc requires a signed release of information. In some cases we may require you to schedule an appointment for the completion of these forms. Please contact our office to inquire whether a scheduled appointment will be necessary. **There may be a fee associated**.

FINANCIAL POLICY

IF YOU DO NOT HAVE INSURANCE:

If you do not have insurance there will be a one-time up front deposit when scheduling your initial appointment. This payment will go towards your first appointment fee. If you cancel your appointment with at least one working day (**24 hours)** notice your payment will be reimbursed in full. If you cancel with less than 24 hours notice or no show your payment is forfeited as a missed appointment fee. We ask that all self pay patients pay in full at the time of service and in turn will be given a discount. If you cannot pay in full we must receive payment before scheduling your next appointment.

IF YOU HAVE INSURANCE:

In order to better serve your needs, our office accepts several insurance plans. However, every plan is different. It is up to the insured to know the exact coverage and limitations of their own insurance plan. In order for us to file insurance claims on your behalf, you must present proper proof of insurance at the time of your appointment to our office. **NO INSURANCE WILL BE FILED WITHOUT A COPY OF THE INSURANCE CARD**

Fees due at the time of service include: co-pays, deductibles, non-covered services, or services to patients that are not covered by insurance. For your convenience we accept, cash, check, MasterCard, Visa, American Express, and Discover. If your check is returned from your financial institution you will be subject to a $30 service charge and we will no longer be able to accept checks on your behalf.

IF YOU HAVE AN OUT OF NETWORK (OON) INSURANCE PLAN:

If your health plan is out of network with our practice we have structured our fees to be competitive in the local market to allow you to see our providers at a reasonable rate. It is our goal that we are accessible to you, and we offer the following payment options for out of network plans:

- Some plans do have out of network benefits. We will be happy to bill your insurance as a courtesy; however payment will be due from you at the time of service. Your insurance carrier will reimburse you directly for any out of network coverage you may have. Additionally, these charges will be applied toward any deductible that you may have to meet.

- Alternately, you may choose to be seen as a self-pay patient. We will not be able to file your insurance for you with this option; however we can offer you **a prompt pay discount when you pay in full on the date of service**. With this option you are welcome to file your insurance claim on your own for possible reimbursement.

FINANCIAL RESPONSIBILITY:

The person who brings a child for care is ultimately responsible for their bill. The physicians will not get involved in a court decision or child support disputes.

YOU WILL RECEIVE A MONTHLY STATEMENT OF YOUR ACCOUNT AS LONG AS YOU HAVE A BALANCE. In general, insurance companies should pay within thirty to sixty days after receipt of a claim. If your insurance has not paid by sixty days after your visit, please check with your company as to the status of your claim. **Your insurance benefits are a contract between you and your insurance company. We cannot accept responsibility for collecting your insurance or for negotiating a settlement on a disputed claim, but we will assist you whenever possible**. If you are a member of a health plan for which we are participating providers, we will honor any restrictions on charges or fees, and these will be adjusted accordingly.

*****WE RESERVE THE RIGHT TO SEND AN ACCOUNT TO COLLECTIONS IF NOT PAID IN FULL. IF KCPG REFERS YOUR ACCOUNT OVER TO A COLLECTION AGENCY, YOU WILL BE RESPONSIBLE FOR YOUR BALANCE PLUS THE COLLECTION AGENCY FEES*****