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 8300 College Blvd., Suite 320, Overland Park, Kansas 66210. 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 contact us at (913)338-0400, option 4 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**.

KCPG

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*****

Kansas City Psychiatric Group

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Kansas City Psychiatric Group is committed to protecting your personal health information. If at any time you have any questions or concerns about how your confidential information is being used you are encouraged to notify the practice staff so that appropriate personnel can quickly address and resolve these concerns.

Effective Date: April 13, 2003
This Notice was revised on July 30, 2018.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Jane Freeman
Mailing Address:	8300 College Blvd, Suite 320, Overland Park, KS 66210
Telephone:	(913)338-0400
Fax:	(913)338-0428

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making

a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Research**. KCPG does not participate in any research activities.

- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others, but we will only disclose the information to someone who may be able to help prevent the threat.

- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of

recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

- **Fundraising Activities.** KCPG does not participate in any fundraising activities.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization, but disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional chosen by KCPG who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.

- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to

the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail. This notice is also available on our website, www.kcpsych.com

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.