

Kansas Surgical Arts

Dear New Patient,

We want to take this opportunity to thank you for choosing our office for your surgical care and to welcome you to our practice.

If you are unable to keep your appointment, please call 24 hours in advance if possible and we will reschedule a more convenient time for you. Your appointment will be for **consultation** only, and if surgery is necessary it will be scheduled for a later date.

In this package you will find *New Patient Instructions* to assist you in preparing for your visit. Please be sure you **bring your X-rays or other films** so the physician will have **all the information** necessary to make recommendations for your care. (See Instructions)

We look forward to seeing you. If you have any questions, please feel free to call our office.

Sincerely,

Kansas Surgical Arts

Kansas Surgical Arts
NEW PATIENT INSTRUCTIONS

Please fill out the enclosed forms **completely**. We will need these completed **before** you see the doctor, [Please fill out these forms in ink only \(preferably black\)](#):

- Patient Information
- Health History

If you have seen another doctor for the same reason, we will need:

- Medical Records
- **BRING** X-rays, CT scans, Ultrasounds, and their reports
-

If your insurance requires a **referral**, you are responsible to call your primary care physician (PCP) to request it. You will need to bring:

- Written referral with you, or
- PCP's office may fax a referral **before** your visit.
- Co-pays are due at the time of check in at the Front Desk, prior to being seen.

These documents are so important, in fact, that their absence will require rescheduling your appointment.

As a courtesy, we try to contact your insurance provider for benefit coverage; however, it is **your responsibility** to know your benefits for either in-network or out-of-network coverage. You should call the number on the back of your insurance card, for benefit information. Please NOTE that acquiring this information is not a guarantee of benefits, rather, it is a way to verify what your insurance may cover. Determination of benefits will be according to provisions stated in your policy.

Patients under the age of **18** will need to be accompanied by a **parent or legal guardian**.

If an **interpreter** is needed, please contact our office in advance.

Medications: Refill requests will be taken between the hours of 9:00 am-4:30 pm Monday to Friday. **No** narcotic drug refills after 4:30 pm or on weekends.

Materials to bring to your first appointment:

*Arrive **30 minutes** early for your initial visit with:

- **Completed forms**
- **Insurance cards and Photo ID**
- **Medical records and films**
- **Written referral and copay** (if required)

For your convenience, we accept Visa, Master Card, American Express and Discover

Thank You

Permission to Disclose Information to Those Involved in My Care

I _____ hereby allow **Kansas Surgical Arts** to disclose the following Protected Health Information to the below listed people, in the following forms of communication:
(print name)

(PLEASE CHECK ALL BOXES THAT APPLY)

Protected Health Information

(What information can we give out?)

<input type="checkbox"/> All <input type="checkbox"/> Appointment times and dates <input type="checkbox"/> Tests that have been received <input type="checkbox"/> Test results <input type="checkbox"/> Other health information
--

People (Name and phone number)

(Who can we give information too?)

<input type="checkbox"/> Self Only OR (Please provide first and last names) <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Family friend _____ <input type="checkbox"/> Child _____ <input type="checkbox"/> Other _____

Forms of Communication

(How may we contact you)

<input type="checkbox"/> Home telephone _____ <input type="checkbox"/> Work telephone _____ <input type="checkbox"/> Home voice messaging system <input type="checkbox"/> Work voice messaging system <input type="checkbox"/> Cellular phone _____ <input type="checkbox"/> E-mail _____ <input type="checkbox"/> Other _____
--

Would you like to receive our newsletter or other health information by E-Mail? Yes No
E-Mail addresses will not be provided to any outside entities.

Patient Signature _____

Kansas Surgical Arts

4013 N. Ridge Road, Suite 110
Wichita, KS 67205

CREDIT POLICY

We at Kansas Surgical Arts want to insure that our patients' health not be compromised or neglected by a harsh or inflexible credit policy. We strive to have a uniform, fair, and consistent procedure for handling of all patient accounts, which encourages the prompt payment of all medical debts through reasonable and effective procedures and follow-up.

Co-Pays

If your insurance requires a co-payment, they require we collect this at the time of your visit.

Payments

We accept cash, checks, debit and credit cards for payment. Cosmetic procedures do not qualify for the credit policy guidelines. Payment in full must be made on day of procedure.

Uninsured Patients

Kansas Surgical Arts does not deny care to patients who find themselves without insurance. All uninsured patients will be required to sign a Patient Payment Agreement before they leave from their first office visit. Uninsured patients may be eligible for an adjusted rate if payment for services rendered is received before the actual service, or on the date of service.

Insurance Claims

Insurance claims will be filed for patient providing appropriate demographic and insurance information. We will file with as many as three insurance companies on behalf of the patient. Copies of the insurance card(s) will be placed in the chart.

Monthly Statements

All patients will receive a monthly statement informing them of the patient balance and the balance pending with the insurance company.

Collections

Patients will be allowed 90 days from the date of patient responsibility to pay off the account balance. If the patient determines that it is not possible to pay the entire account balance within 90 days, reasonable monthly payments will be considered. A payment plan can be set up through our accounts department. If payment has not been received within 90 days, we will begin taking steps to send the account to collections.

Hardship

If a patient feels that they have extenuating circumstances that prevent them from paying a portion or their entire bill, they may fill out a "Request for Waiver of Payment Due to Economic Hardship" form. This form is to be filled out and brought back to us with the required proof. We will review each request and the patient will be notified as to our decision regarding their situation. **Filling out a request form does not guarantee that part or all of your outstanding balance will be waived.** A new request form and hardship documentation must be obtained and submitted for each occurrence.

Lack of Cooperation

Kansas Surgical Arts believes that all patients should be treated with dignity regardless of their ability to pay. Kansas Surgical Arts reserves the right to terminate a patient from the practice in those rare cases when a patient may be verbally or physically abusive, refuses to give necessary information, or is non-compliant with medical advice.

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Wichita, KS 67205

NOTICE OF PRIVACY PRACTICES

(Overview)

We value you as a customer and take your personal privacy seriously. Our practice, physicians, and staff strive to respect the patient's dignity at all times. We work hard to maintain your privacy and are very careful to preserve the private nature of our relationship with you. The only information we provide to outside companies is that which is required to provide services on your behalf and for which you have signed consent. In every case in which information is provided, the companies are obligated by law to use the information as contracted and to keep this information confidential.

To serve you better and manage our practice, it is important that we collect and maintain accurate personal information about you. We will always limit our collection of information to that which we believe is necessary to conduct our business properly and provide optimum service to you.

This privacy policy is provided to you as required by Federal law. It simply documents for you our long-standing privacy practices. If you have any questions regarding this policy, please contact us at 945-7309.

NOTICE OF PATIENT RIGHTS

(Overview)

As a patient of Kansas Surgical Arts, you have the following patient rights in regards to your Personal Health Information (PHI).

The right to authorize the use and disclosure of your PHI.

- you have the right to request the nature in which our practice communicates information with you.

Ex: You may ask that we contact you at home, rather than at work.

The right to receive a copy of the practice's Notice of Privacy Practices.

The right to request restriction on certain uses and disclosures of your PHI.

The right to request restrictions on how the practice communicates PHI to the patient.

The right to request an amendment of your PHI if you feel it is incorrect or incomplete.

The right to inspect and copy your PHI.

The right to an accounting of the disclosures of your PHI.

The right to file a complaint.

Kansas Surgical Arts - Patient Information

(Please Print – Use Black Ink Only)

Date _____ Referring Doctor _____
Primary Care Physician _____
Preferred Pharmacy & Phone Number _____

Patient's Name _____

Address _____

City _____ State/Zip _____ Email _____

Home Phone _____ Cell Phone _____

Birth date _____ Age _____ Social Security # _____

Sex M F Marital Status Single Married Divorced Widowed Separated

Patient's Employer _____ Business Phone # _____

Spouse/Parent's Name _____

Social Security # _____ Birth date _____

Spouse/Parent's Employer _____ Business Phone# _____

In case of emergency, whom may we contact? (Someone who is NOT living with you.)

Name _____

Relationship _____ Phone _____

(Initials) I have received a copy of Kansas Surgical Arts "Credit Policy". I have read and agree to this policy.

(Initials) I have received a copy of Kansas Surgical Arts HIPPA policy. I have read and agree to this policy.

Insurance

In order for your insurance company to be billed, we MUST have copies of your cards on file. Without copies, the bill will be your responsibility.

PRIMARY Insurance Co. _____ Policy Holder _____

SECONDARY Insurance Co. _____ Policy Holder _____

Other Insurance Co. _____ Policy Holder _____

Assignment and Release

I hereby authorize Kansas Surgical Arts to release information requested by my insurance company, to any hospital or physician this office may refer me to. I hereby authorize assignment and payment directly to Kansas Surgical Arts major medical benefits due me.

X

Signature of Responsible Party Relationship to Patient Date

Account No. _____

Kansas Surgical Arts – Current Symptoms Review

Acct. Number: _____

Current Symptoms Review (Check all that have occurred Recently, explain if needed)			
Constitutional	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever	<input type="checkbox"/> Chills <input type="checkbox"/> Body aches	<input type="checkbox"/> Night sweats <input type="checkbox"/> <i>No Current Problems</i>
HEENT	<input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo (Dizziness)	<input type="checkbox"/> Dental Problems <input type="checkbox"/> Sore throat	<input type="checkbox"/> Neck Tenderness <input type="checkbox"/> <i>No Current Problems</i>
Breast	<input type="checkbox"/> Lumps <input type="checkbox"/> Tenderness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Discharge <input type="checkbox"/> <i>No Current Problems</i>
Cardiovascular	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Claudication (Leg cramps with exercise) <input type="checkbox"/> Syncope (Passing out) <input type="checkbox"/> Leg heaviness <input type="checkbox"/> Restless legs <input type="checkbox"/> Leg pain	<input type="checkbox"/> Orthostatic symptoms (Dizzy when getting up too fast) <input type="checkbox"/> Orthopnea (Short of breath when lying down) <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Leg fatigue	<input type="checkbox"/> Dyspnea on Exertion (Shortness of breath) <input type="checkbox"/> Cyanosis (Discoloration of feet, hands, lips) <input type="checkbox"/> Lower extremity edema <input type="checkbox"/> Varicosities <input type="checkbox"/> <i>No Current Problems</i>
Respiratory	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarseness <input type="checkbox"/> <i>No Current Problems</i>
Gastrointestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Reflux	<input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> <i>No Current Problems</i>
Genitourinary/ Gynecological	<input type="checkbox"/> Urgency <input type="checkbox"/> Frequency	<input type="checkbox"/> Urinary burning/pain <input type="checkbox"/> Hematuria (Blood in urine)	<input type="checkbox"/> <i>No Current Problems</i>
Integument	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Pigmentation changes	<input type="checkbox"/> Skin dryness <input type="checkbox"/> New skin lesions <input type="checkbox"/> Leg ulcers & sores	<input type="checkbox"/> Nail changes <input type="checkbox"/> Changes to existing skin lesions or moles <input type="checkbox"/> <i>No Current Problems</i>
Neurologic	<input type="checkbox"/> Tingling or numbness (Legs & Feet)	<input type="checkbox"/> Tingling or numbness (Arms & Hands)	<input type="checkbox"/> Seizures <input type="checkbox"/> <i>No Current Problems</i>
Musculoskeletal	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint swelling	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Muscle cramps <input type="checkbox"/> <i>No Current Problems</i>
Endocrine	<input type="checkbox"/> Weight loss <input type="checkbox"/> Loss of hair	<input type="checkbox"/> Weight gain <input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Heat intolerance <input type="checkbox"/> <i>No Current Problems</i>
Psychiatric	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> <i>No Current Problems</i>
Heme-Lymphatics	<input type="checkbox"/> Lymph node Enlargement or tenderness	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Easy bruising <input type="checkbox"/> <i>No Current Problems</i>
Allergic-Immunologic	<input type="checkbox"/> Sinus allergy symptoms	<input type="checkbox"/> Allergic dermatitis	<input type="checkbox"/> <i>No Current Problems</i>

Thank you for taking the time to fill out this questionnaire. It helps us to find out details about each patient's problem(s). The information you give is vital to providing you with the optimum and efficient care. Please ask for any explanation or assistance in completing this questionnaire.

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Signature of the Patient (or the person who filled out this form) _____

Kansas Surgical Arts – Patient Medical History Form

Today's Date: _____

Acct. Number: _____

Patient Name: _____

Date of Birth: _____

Signature of the Patient (or the person who filled out this form) **X** _____

PLEASE use black ink. Fill in or check the appropriate response. Additional questions are on next page.

1. What is the reason for your visit? _____

2. Is your problem due to an accident? (check all that apply): Yes No. Due to: Work.

3. Rate your current health poor fair good very good excellent

4. Past Medical History (Check all boxes that apply):

Head, eyes, ears, nose and throat (HEENT)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Glasses	<input type="checkbox"/> Dentures	<input type="checkbox"/> NONE
	List others: _____			
Heart , Blood Pressure, Veins (Cardiovascular)	<input type="checkbox"/> Abdominal aneurysm	<input type="checkbox"/> Venous stasis ulcers	<input type="checkbox"/> Thoracic aortic aneurysm	
	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Venous congestion	<input type="checkbox"/> Stroke (CVA)	
	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Valvular disorders	<input type="checkbox"/> High blood pressure	
	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Deep venous thrombosis (DVT)	<input type="checkbox"/> Low blood pressure	
	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Peripheral vascular occlusive disease	<input type="checkbox"/> Heart murmur	
	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> NONE
	List others: _____			
Lungs (Pulmonary)	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD (Chronic obstructive pulmonary disease)	<input type="checkbox"/> Chronic bronchitis	
	<input type="checkbox"/> Emphysema	Do you use CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tuberculosis	
	<input type="checkbox"/> Sleep Apnea		<input type="checkbox"/> NONE	
	List others: _____			
Thyroid, Pancreas (Endocrine)	<input type="checkbox"/> Hyperthyroidism (high)	<input type="checkbox"/> Hypothyroidism (low)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> NONE
	List others: _____			
Stomach, Bowels (Gastrointestinal)	<input type="checkbox"/> Colitis	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Diverticulitis	
	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Gastroesophageal reflux disease (GERD)	
	<input type="checkbox"/> Barrett's	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Ulcers (Stomach)	
	<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Cirrhosis	
	<input type="checkbox"/> Colon polys(s)	*frequency of your Bowel movements:	<input type="checkbox"/> NONE	
	List others: _____			
Kidneys, Bladder (Genitourinary)	<input type="checkbox"/> Renal failure	<input type="checkbox"/> Kidney stones (Nephrolithiasis)	<input type="checkbox"/> Dialysis	<input type="checkbox"/> NONE
	List others: _____			
Blood Disorders (Immune and Hematological)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> AIDS/HIV	
	Type: _____	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Anemia	
	List others: _____			

Cancer (Neoplastic)	<input type="checkbox"/> Lung	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Skin
	<input type="checkbox"/> Breast	<input type="checkbox"/> Uterus/Cervix	<input type="checkbox"/> Bone
	<input type="checkbox"/> Prostate	<input type="checkbox"/> Bladder	<input type="checkbox"/> Lymphoma
	<input type="checkbox"/> Colon cancer/polyp	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Kidney
			<input type="checkbox"/> NONE
	List others:		
Neurological	<input type="checkbox"/> Parkinsons	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Fibromyalgia
	<input type="checkbox"/> Seizures		<input type="checkbox"/> NONE
	List others:		
Psychiatric	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> NONE
	List others:		
Women's Health	<input type="checkbox"/> Menopausal	Date – Last mammogram:	Date – Last pap smear & pelvic:
	List others:		

Explain above in detail if needed: _____

5. Past Surgical History			
Date of Last Colonoscopy:			
And findings:			
Have you had any problems with anesthesia: <input type="checkbox"/> Yes <input type="checkbox"/> No		Explain:	
Type of Surgery	When	Where	Surgeon
<input type="checkbox"/> No Past Surgical History			

6. Current Medications	Dosage (mg)	Frequency	Prescribing Physician
<input type="checkbox"/> No Current Medications			

Patient Name: _____ **Date of Birth:** _____

6. Current Medications (Cont'd)	Dosage (mg)	Frequency	Prescribing Physician

7. Allergies (Drugs, food, environmental)	Reactions
<input type="checkbox"/> No Known Allergies	
<input type="checkbox"/> LATEX Allergy <input type="checkbox"/> LATEX Sensitivity	

8. Reproductive History	Number of pregnancies:	Number of living children:

9. Family History <input type="checkbox"/> Adopted - Family History Unknown Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column. <input type="checkbox"/> No Family History of Problems listed Below	Mother	Father	Brother	Sister	(maternal)Grandmother	(paternal)Grandmother	(maternal)Grandfather	(paternal)Grandfather
	Heart Disease							
High Blood Pressure								
Varicose Veins								
Diabetes								
Colon Polyp(s)								
Cancer, and please list type								

10. Social History			
What is your current occupation?			
Work Status	<input type="checkbox"/> Working <input type="checkbox"/> Not working <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired		
Tobacco Use/Smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes	Packs per day:	Number of years: Type of tobacco?
Alcohol Use	<input type="checkbox"/> No <input type="checkbox"/> Yes	Drinks per week:	What type of alcohol?

Patient Name: _____ **Date of Birth:** _____

Vein Patient (If you are not seeing the doctor for leg problems you may skip this form).

Initial Review of Body Systems

(Check all that are applicable and **explain** if needed)

Constitutional	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever	<input type="checkbox"/> Chills <input type="checkbox"/> Body aches	<input type="checkbox"/> Night sweats <input type="checkbox"/> None
HEENT	<input type="checkbox"/> Headaches <input type="checkbox"/> Vertigo (Dizziness)	<input type="checkbox"/> Dental Problems <input type="checkbox"/> Neck pain	<input type="checkbox"/> Neck Tenderness <input type="checkbox"/> Sore throat <input type="checkbox"/> None
Breast	<input type="checkbox"/> Lumps <input type="checkbox"/> Tenderness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Discharge <input type="checkbox"/> None
Cardiovascular Venous	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Claudication (Leg cramps with exercise) <input type="checkbox"/> Syncope (Passing out)	<input type="checkbox"/> Orthostatic symptoms (Dizzy when getting up too fast) <input type="checkbox"/> Orthopnea (Short of breath when lying down) <input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Dyspnea on Exertion (Shortness of breath) <input type="checkbox"/> Cyanosis (Discoloration of feet, hands, lips) <input type="checkbox"/> None
Respiratory	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Hoarseness <input type="checkbox"/> None
Gastrointestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Reflux	<input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> None
Genitourinary/ Gynecological	<input type="checkbox"/> Urgency	<input type="checkbox"/> Possible pregnancy	<input type="checkbox"/> Frequency <input type="checkbox"/> None
Integument	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Pigmentation changes	<input type="checkbox"/> Skin dryness <input type="checkbox"/> Changes to existing skin lesions or moles	<input type="checkbox"/> Nail changes <input type="checkbox"/> New skin lesions <input type="checkbox"/> None
Neurologic	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tingling or numbness (Arms & Hands)	<input type="checkbox"/> Speech difficulties <input type="checkbox"/> None
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle cramps <input type="checkbox"/> None
Endocrine	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> None
Psychiatric	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> None
Heme-Lymphatics	<input type="checkbox"/> Lymph node Enlargement or tenderness	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Easy bruising <input type="checkbox"/> None
Allergic-Immunologic	<input type="checkbox"/> Sinus allergy symptoms	<input type="checkbox"/> Allergic dermatitis	<input type="checkbox"/> None

Thank you for taking the time to fill out this questionnaire. It helps us to find out details about each new patient's problem. The information you give is vital to providing you with the optimum and efficient care. Please ask for any explanation or assistance in completing this questionnaire.

Patient Name: X _____ **Date of Birth:** _____