If you're a new patient, please circle one of the following to help us know how you heard about KC Urology:

PCP Radio Social Media TV Billboard Other___________ Date: ______________________

PATIENT INFORMATION

Patient Name: ________________________ DOB: ______________ Age: ______________

Address: ________________________ City/State: ______________ Zip: ______________

Male or Female (circle one) Social Security #: ______________ Marital Status S__M__LP__D__W__ No. of Children: ________

Race (circle one): White Black/African American Asian American Indian Multiracial Other Decline to Specify

Ethnicity (circle one): Hispanic Not Hispanic Other Decline to Specify Preferred Language: ______________

Home Phone: ______________ Cell Phone: ______________ e-mail: ______________

Referring Physician: ________________________ Phone: ______________

Primary Care Physician: ________________________ Phone: ______________

Primary Pharmacy: ________________________ Address: ______________

City/State/Zip: ________________________ Phone #: ______________

Mail Order Pharmacy: ________________________ Address: ______________

City/State/Zip: ________________________ Phone #: ______________

Insurance

Will VA benefits be used for this visit? __________ If yes, please provide the referral #: ______________

Is the patient employed? ______________ If yes, are you covered by a Group Health Plan? ______________

Is this patient covered under a COBRA policy? _________

Is this service related to a Work Comp accident or an Auto accident? ____________ If yes, you will be provided additional forms

Primary Insurance: ________________________ ID#______________ Group # ______________

Insured's Name: ________________________ Date of Birth: ______________

Relationship to Patient: ________________________ Contact Phone #: ______________

Secondary Insurance: ________________________ ID# ______________ Group # ______________

Insured's Name: ________________________ Date of Birth: ______________

Relationship to Patient: ________________________ Contact Phone #: ______________

Emergency PATIENT SPOUSAL / PARENT CONTACT INFORMATION

Name: ________________________ Relationship to Patient ______________

Home Phone: ________________________ Cell Phone: ______________

____
(Patient Name)

INSURANCE CONSENT

I hereby authorize release of information to my insurance companies and payments to be made directly to my physicians. This form may be used for all of my insurance companies, and I authorize this Practice to act as my agent to help me secure payment from my insurance companies.

MEDICAL RECORDS RELEASE AUTHORIZATION

I authorize Kansas City Urology Care, PA to release to the appropriate person, corporation, or other entity any diagnostic and therapeutic information (including any treatment for alcohol or drug abuse and any psychiatric or psychological treatment) as may be necessary to determine health care benefits entitlement for me under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of doctors and other health care providers. I authorize Kansas City Urology Care, PA to process payment claims for health care services provided to me. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by Kansas City Urology Care, PA upon the Practice's request. The Practice may utilize information in my medical record that is necessary for research for quality improvement purposes.

AUTHORIZATION TO RELEASE INFORMATION

Kansas City Urology Care, PA uses the Epic EMR through Saint Luke's Health System (SLHS). I consent to the sharing of my health information within the SLHS for the purposes of treatment, payment, and healthcare operations. I understand that SLHS participates in various electronic health information exchanges designed to ensure my health information is available to all persons and entities providing me with care, payment for that care, or for other purposes permitted by law. This includes health information exchanges through Epic's Care Everywhere, and any other health information exchanges that SLHS participates in (collectively, the "Exchanges", full listing available at saintlukeskc.org/HIE). I understand that SLHS may disclose my health information to the Exchanges, and access my health information in the Exchanges, as outlined in this Consent. As the patient, I may choose to opt-out of providing this access by sending a request to medicalrecords@saintlukeskc.org using the subject line "HIE Opt-Out." Please include Patient Full Name, Date of Birth, and Phone Number so we can verify the request. To revoke this, opt-out request, send a request to medicalrecords@saintlukeskc.org using the subject line "Revoke HIE Opt-Out". Please include Patient Full Name, Date of Birth, and Phone Number so we can verify the request.

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations set forth in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Kansas City Urology Care, PA has made available its Notice of Privacy Practice (Notice) to me, which describes how a patient's health information is used and shared. I acknowledge the Practice has offered to provide me with access to its Notice in paper copy or by email, in whichever manner of delivery that I prefer. The Notice is also available at www.kcuc.com/wp-content/uploads/2020/11/KCUC-Notice-of-Privacy-Practices-November-2020.pdf. I understand that Kansas City Urology Care, PA has the right to change this Notice at any time, and if the Notice changes, a current copy may be obtained by contacting Kansas City Urology Care, PA or by visiting the Kansas City Urology Care, PA website.

USE OF CONTACT INFORMATION: TELEPHONE CONSUMER PROTECTION ACT (TCPA) ________**Initials**

I have reviewed Kansas City Urology Care, PA's Notice of Privacy Practices (Notice) where it discusses how the Practice may use my contact information. By initialing and signing below, I agree that the Practice, along with its affiliates and vendors, may call or text me as set forth in the Notice, including, but not limited to, using an automated telephone dialing system and/or an artificial voice. I understand that I can opt out at any time by notifying the Practice and/or the affiliate/vendor.

FINANCIAL POLICY & PAYMENT GUARANTEE

I have read and fully understand the financial policy set forth by Kansas City Urology Care, PA, at www.kcuc.com/resources/patient-financial-policy/, and I agree to the terms of this financial policy. I agree that the terms of the financial policy may be amended by the Practice at any time without prior notification to me, the patient. I understand that, in consideration of the services rendered to me, I am subject to all attorney fees, collection charges, and any other changes incurred if my portion of the bill is not paid when it is due.

DME WARRANTY COVERAGE

I understand Kansas City Urology Care, PA honors all warranties of manufacturers of the equipment the Practice provides.

MEDICARE BENEFITS CONSENT

If I am covered by Medicare, I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my, as the patient's, behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit claim to Medicare for payment to the patient.

Patient/Legal Representative Signature:______________________________Date:________________________

Print Name:______________________________________Relationship to Patient:________________________