

|  |  |   |                  |                                    |            |
|--|--|---|------------------|------------------------------------|------------|
| TODAY'S DATE<br><br>/ /  | <b>PATIENT INFORMATION /CONSENT TO TREAT /HIPPA FORM<br/>FLINT HILLS FAMILY MEDICINE</b> |   |                  |                                    |            |
| <b>PATIENT INFORMATION — PLEASE PRINT</b>                      |  |   |                  |                                    |            |
| FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)                        |  |   |                  |                                    |            |
| ADDRESS:   |  | CITY:   | STATE:           |                                    | ZIP:       |
| SOCIAL SECURITY NUMBER:  | Provider ( please circle)<br>Dr. Schmid<br><br>Dr. Hrabik                                | Please circle ( child, employed, student<br>Military) |                  | HOME PHONE NUMBER:                 |            |
| DATE OF BIRTH:   | E-MAIL ADDRESS:  |   |                  | MARITAL STATUS:                    |            |
| EMPLOYER NAME:   | BUSINESS PHONE:  | EXTENSION:  | OCCUPATION:      |                                    |            |
| EMPLOYER STREET ADDRESS:                                       |  | CITY:   | STATE:           |                                    | ZIP:       |
| <b>RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)</b> |  |   |                  |                                    |            |
| FULL LEGAL NAME (FIRST) (MIDDLE) (LAST)                        |  |   |                  | RELATIONSHIP: spouse, parent, ect. |            |
| ADDRESS (IF DIFFERENT THAN ABOVE)                              |  | CITY  | STATE            | ZIP                                | HOME PHONE |
| SOCIAL SECURITY NUMBER:  | DATE OF BIRTH:   | BUSINESS PHONE:                                       |                  | EXT.                               |            |
| EMPLOYER NAME:   | STREET ADDRESS:  |   | CITY:            | STATE:                             | ZIP:       |
| <b>CONCERNING INSURANCE</b>                                    |  |   |                  |                                    |            |
| PRIMARY INSURANCE COMPANY NAME                                 |  | GROUP #   | ID/CERTIFICATE # |                                    |            |
| SUBSCRIBER NAME  |  |   |                  |                                    |            |
| SECONDARY INSURANCE COMPANY NAME                               |  | GROUP #   | ID/CERTIFICATE # |                                    |            |
| SUBSCRIBER NAME  |  |   |                  |                                    |            |
| OTHER INSURANCE INFORMATION                                    |  |   |                  |                                    |            |
| <b>EMERGENCY AND OTHER INFORMATION</b>                         |  |   |                  |                                    |            |
| PERSON TO NOTIFY IN CASE OF EMERGENCY                          |  |   | RELATIONSHIP     |                                    |            |
| ADDRESS (NUMBER) (STREET)                                      |  |   |                  | (APT #)                            |            |
| CITY   |  | STATE   | ZIP              | HOME PHONE                         |            |
| OTHER DOCTORS YOU SEE  |  |   |                  |                                    |            |
| HOW DID YOU HEAR ABOUT US?                                     |  |   |                  |                                    |            |
| <b>INFORMATION</b>   |  |   |                  |                                    |            |

Insurance will be billed for all HMO's and PPO's with which we are contracted.

We accept assignment for Medicare; however, the patient is responsible for the copayment which Medicare calculates.

**PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICES EVEN THOUGH YOU MAY HAVE INSURANCE COVERAGE**—this means that should the insurer fail to pay any sums due, you are responsible for their payment.