Mid-Kansas Women's Center, PA

Patient Information

Last Name | First Name | MI | Preferred or Nickname | Maiden Name

DOB | Sex

SSN | Marital Status

Primary Language | Race | Ethnicity

Preferred Provider

Preferred Pharmacy and Address

Primary Care Physician

Address | Apt

City | State | Zip

Email Address

Primary Phone #

Cell Phone #

Work Phone #

Emergency Contact Name

Relationship

Phone #

Responsible Party

Full Name | Relationship to Patient | DOB | Phone # | Work Phone #

Insurance

Primary Insurance | Policy Holder's Name | Relationship to Insured | Policy Number | Group Number

Secondary Insurance | Policy Holder's Name | Relationship to Insured | Policy Number | Group Number

RELEASE OF INFORMATION

May we give out any medical/financial information to anyone other than yourself, your treating physician, or insurance company?

Yes _____ No _____ If Yes, to whom:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

E-PRESCRIBE AND PHARMACY BENEFITS MANAGEMENT PROGRAM (PBM)

ePrescribing allows physicians to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Benefits are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs who provide medication history and maintain formularies, or lists of drugs covered by a particular drug benefit plan. Having this information allows your provider to help you find the most beneficial and cost-effective treatments while improving your overall care.

By signing this consent form at the bottom of the page, you are agreeing that Mid-Kansas Woman's Health can request and use your prescription medication history from other health care providers and/or third party benefit payers for treatment purposes.

PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of this clinic's Notice of Privacy Practices.

I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If item 12of CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above in Medicare/Other Insurance Company assigned cases. Co-pay must be paid at time of service. Please let us know if you need more information.

Patient Name (Print): _____

Signature of Patient: _____ Date: _____