CONTINUUM
HEALTH CARE

11661 College Blvd. Suite 100

Overland Park, KS 66210

Tel. (913) 954-8500 Fax (913) 432-8402

NEW PATIENT PACKET

Registration Information			
Patient Name:		Gender: ___M ___F	
Date of Birth:	Race:	Marital Status: S M W D	
Social Security:	Email:		
Home Phone:	Cell:	Primary:	
Address:			
City:	State:	Zip:	
Durable Power of Attorney ___YES ___ NO if yes please submit a copy			

Please give the name and phone number of a relative or friend not living with you whom we may contact in the event of a medical emergency.

Emergency Contact Information	Phone
Name:	Home:
Address:	Work:
Relationship to Patient:	Cell:

Primary Insurance Information	
Name:	Phone:
Subscriber Name:	DOB:
Policy Number:	

Preferred Pharmacy	
Name:	Phone:
Address:	Fax:

Patient Portal (Non-urgent Communication)

- To sign up for patient portal please provide us with your e-mail address and ask our receptionist to send you an invite.
- Our secure portal allows patients and care teams to interact, before, during and after office hours.
- Patients can schedule their own non-urgent appointments, May request medication refills and referrals.
- The portal allows patients to pay bills and check their lab results

Appointment Date:	Time:

Please bring to every appointment: Current Medication List, Photo ID, Insurance Cards and Co-payment.

Patient Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY							
Check All That Apply	Alcohol/ Drug Abuse	Asthma	Diabetes	Heart Disease	High Cholesterol	Stroke	Other: _____
Mother							
Father							
Brother							
Sister							
Grandparent							
Other _____							

Please list all medications you are currently taking. Include over the counter medications, herbs, and vitamins.

(If you have a list please submit with your form)

Medication	Dosage	How often	Medication	Dosage	How often

Please list ALLERGIES to medications and your reaction.

Medication	Reaction

CONTINUUM HEALTH CARE POLICIES

Appointment Cancellation:

To meet the needs of all our patients, we require a 24-hour notice for all cancellations. Failure to do so will result in a $25 fee.

No Show Appointment Fee:

Failure to show to your scheduled appointments will result in a $30 fee and will be added to your account and collected prior to your next appointment.

Late for an appointment:

Please understand that we reserve the right to reschedule your appointment to a future date if you are more than 15 minutes late for your appointment. If you are unable to arrive at your appointment on time, we appreciate your courtesy of letting us know as far in advance as possible.

Return Check:

A $30 fee will be charged for any returned check.

Payment for Service and Bankruptcy

All co-pays, additional fees, or cash payments are due before the time of service.

Should the patient file for bankruptcy, we reserve the right to collect the patient responsibility fee in advance at the time of the visit.

I hereby authorize the performance of all treatments, minor procedures, venipuncture, and radiology deemed advisable by the providers of Continuum Health Care. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I am responsible to verify insurance coverage and benefits. I agree to pay legal interest, collection expenses, and attorney fees. I am aware that the practice of medicine is not an exact science, and no one has any guarantees regarding the results of treatments, examinations, or procedures. I understand this agreement and my consent will continue until cancelled by the patient or guarantor in writing. My signature acknowledges that I was provided with a copy of Continuum Health Care's Notice of Privacy Practices

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_____

Patient/Authorized Representative Signature

_____ Date: _____

Patient Name

Patient Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

In our practice we contact patients regarding appointments, scheduling, lab results, billing, and /or payment questions on your account, etc. In addition, unforeseeable emergencies do sometimes arise when it may be necessary for the physician or staff to contact you. It is our office policy to leave a message at primary phone and if you are not available or we may need to contact you at your home Phone Number.

	(Please circle one)	
May we contact you at Home Number?	YES	NO
May we contact your Cell Number?	YES	NO
May we leave a message on your answering machine at home?	YES	NO
May we leave a message on your Cell Phone?	YES	NO

AUTHORIZATION TO RELEASE INFORMATION

This office adheres to strict policies regarding the release of confidential information. I understand that your policy is not to disclose any personal health information to other parties, except those directly involved in my care, without my written authorization or permitted by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with or facilitating my care.

AUTHORIZED REPRESENTATIVE

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I understand that I have the right to limit the information that you release under this authorization. I may limit my Authorized Representative access to information about a diagnosis/disease. Any such limitations must be described in writing.

_____ Date: _____
Patient/Authorized Representative Signature

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient: _____ Date of Birth: _____

Records Dated From: _____To: _____ □ Check for All Medical Records

By signing this form, I authorize the release of confidential health information TO:

Continuum Health Care
Attn: Medical Records
11661 College Boulevard Overland Park, KS 66210
Phone#: (913) 954-8500 Fax #: (913) 432-8402

INFORMATION TO BE RELEASED:

□ History & Physical □ Consultation Report □ Emergency Room Records
□ Operative Reports □ Discharge Summary □ Face Sheet
□ Referral Record(s) Other: _____

Please specify destination to which records are to be released FROM:

Name of Location: _____

Name of Physician: _____

Address: _____

Phone #: _____ Fax #: _____

- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
- I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
- The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

_____ Date: _____
Patient/Authorized Representative Signature