Labette Health Physicians Group

St. Paul Clinic 200 Carroll St. Paul, KS 66771	***Cherryvale Clinic*** 116 North Maple Cherryvale, KS 67335	***Altamont Clinic*** 607 E. 4th Street Altamont, KS 67330	***Erie Clinic*** 324 S. Main Street Erie, KS 66733	***Dr. Buller's Clinic*** 1902 S. Hwy 59, Bldg A, Ste 8 Parsons, KS 67357	***Chetopa Clinic*** 613 Maple Chetopa, KS 67336

Advanced Ob/Gyn Assoc 1902 S. Hwy 59, Bldg E, Ste 301 Parsons, KS 67357	***Dr. Bolt's General Surgery Clinic*** 1902 S. Hwy 59, Bldg E, Ste 300 Parsons, KS 67357	***Parsons Specialists Clinic*** 1902 S. Hwy 59, Bldg E, Ste 200 Parsons, KS 67357	***Independence Specialists Clinic*** 510 N. Peter Pan Road, Ste B2 Independence, KS 67301	***Physiatry, Urology, & Neurosurgery Clinic*** 1902 S. Hwy 59, Bldg E, Ste 201 Parsons, KS 67357	***Internal Medicine & Pediatrics Clinic*** 1902 S. Hwy 59, Bldg E, Ste 204 Parsons, KS 67357

Family Practice Clinic & Express Care 1902 S Hwy 59, Bldg E, Ste 101 Parsons, KS 67357	***Independence Clinic & Express Care*** 510 N. Peter Pan Road, Ste B1 Independence, KS 67301	***Chanute Clinic & Express Care*** 2613 S. Santa Fe Avenue Chanute, KS 66720	***Oswego Clinic & Express Care*** 608 Commercial Oswego, KS 67356	***Women's & Children's Clinic*** 209 N. 6th Street, Ste. 103 Independence, KS 67301	***Coffeyville Clinic*** 801 W. 8th Street Coffeyville, KS 67337

PATIENT INFORMATION

Primary Care Provider: _____ **Preferred Pharmacy:** Please see pharmacy consent below

Preferred Method of Contact for Reminder Calls	Primary Language	Gender	Marital Status	Race	Ethnicity
☐ Phone Home or Mobile ☐ Text Message ☐ Email	☐ English ☐ Spanish Other:	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Widow	☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Alaskan Native ☐ Black/African American ☐ White ☐ Declined ☐ Other _____	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Last Name: _____ **First:** _____ **MI:** _____ ***Preferred:*** _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Home) _____ (Cell) (Please see consent below) DOB: _____ SSN: _____

Enjoy online conveniences with access to our PATIENT PORTAL. Please give us your email address to sign up. Email Address: _____

Employer: _____ Employer Phone: _____

Policy Holder or Person Responsible for patient: (If minor, Parent or Guardian)

Last Name: _____ First: _____ MI: _____ Relationship _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Home) _____ (Cell) DOB: _____ SSN: _____

Employer: _____ Employer Phone: _____

Insurance Information: (Please give card to receptionist to copy)

Primary: _____ Secondary: _____ Tertiary: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO VIEW A COPY OF LABETTE HEALTH'S NOTICE OF PRIVACY PRACTICES.

I also acknowledge that I realize and understand that THIS IS A DIRECT **ASSIGNMENT OF MY RIGHTS AND BENEFITS** UNDER THE INSURANCE COMPANY LISTED, MEDICARE/CMS, MEDIGAP AND/OR MEDICAID (KanCare). This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of the said professional service charges over and above the insurance payment. If I do not have insurance, I understand I will be responsible for the payment in full of services rendered to me.

CONSENT FOR HEALTHCARE: Patient voluntarily consents to such medical care including, but not limited to, laboratory, diagnostic or medical treatment which may be ordered by patient's physician or assistants, or designees for medical treatment which they may deem necessary and advisable. Patient reserves the right to refuse specific treatment plans as may be directed by the provider or their designees.
PBM - PHARMACY CONSENT: With your signature below, you consent for your healthcare provider to electronically access information regarding your drug benefit coverage and medication history for an indefinite (lifetime) period or for the period so indicated here _____.
CELL PHONE CONSENT: By providing your cell phone number above and signing below, you consent to the use of your cell phone number as an appropriate means of communication by your healthcare provider or their representatives for the purpose of treatment, payment or operations
MESSAGE CONSENT: Patient agrees by signing below to give permission to the clinic, their representatives or representative agencies to leave a phone or text message on the phone, voicemail or answering machine of the numbers listed above or any other contact number that has been deemed a contact number for the patient.

The agreements and assignments will remain in effect for one year from the date of signature or until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I, the undersigned, authorize Labette Health Physicians Group to release any information pertinent to my case to any insurance company, adjuster, physician, employee or agent of Labette Health for the purpose of utilization review, quality assurance and/or billing.

Patient Signature (if over 18 or legal representative if under 18): By typing your name here, we are accepting this as your digital signature **Date:** _____

Printed Name of Person Signing _____ **Relationship to Patient** _____

☐ **Patient was unable/unwilling to sign document:** **Reason:** _____ **Staff initials:** _____ **Date:** _____

Submit

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