KNOLL Clinic 1100 E 22nd Street Hays, Kansas 67601 P: 785-625-5500 FX: 785-625-5501
E-mail: tknoll@knollclinic.com

Patient Information

Full Name: _____

Birthdate: _____ SS#:_____

Race: _____ Age: _____ Female or Male

Ethnicity: Hispanic Non-Hispanic Declined

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Insurance Information

Primary Insurance

Medicare BCBS Work Comp None

Other: _____

Secondary Insurance: _____

PHARMACY INFORMATION

Name: _____

Address: _____

Phone: _____

Employment Information

Employer: _____

Work Phone: _____

Employer Address: _____

Emergency Medical Contact

Contact Name: _____

Relationship: _____

Phone Number: _____

Spouse Information

Full Name: _____

Birthdate: _____ SS#:_____

Employer_____

Work Phone: _____

Cell Phone:_____

Medicare Screening Information

Is the patient a veteran? **YES** **NO**

If YES:

Did the VA Refer the patient? **YES** **NO**

Does the patient have fee basis ID card? **YES** **NO**

Does the patient have a Federal Black Lung Card? **YES** **NO**

Is this visit due to an accident? **YES** **NO**

How did you hear about us?

Website, Phonebook, Word of Mouth (Who? :_____), or Other (Please List): _____

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Means of Communication

Patient: _____DOB_____

Knoll Clinic may communicate with me as follows about my appointments, test results, treatment options, breach notification, or any other matter related to my treatment or payment of my treatment. **If you decline to give such permission, check "NO." At least one box must be marked "YES."**

YES	NO	
___	___	Calling me at my home phone number: Phone #:_____
___	___	Leaving message on my home voice mail.
___	___	Calling me at my work phone number. Phone #:_____
___	___	Leaving message on my work voicemail.
___	___	Calling me at my cell phone number. Phone #:_____
___	___	Texting me at my cell phone number.
		(by selecting "no" patients may still receive general information texts related to closings or general office information or changes)
___	___	Leaving message on my cell phone number.
___	___	E-mailing me at_____
		(I understand that such communications will not be encrypted)
___	___	Leaving a message with any individual who answers my phone(s)

Please notify the staff if you wish to make any changes to these directives.

I understand and agree to the Means of Communication as above.

Patient/Guardian Signature: _____

Printed: _____

Date: _____

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Persons involved in care or payment for care

I authorize Knoll Clinic to disclose my protected health information (including scheduled/rescheduled appointments, test results, diagnoses, treatment plan, billing questions, etc.) to the following people involved in my care or payment of care. *If you decline such permission, leave the following blank.*

Signature_____ **Date**_____

Name_____ Relationship to patient_____ Phone_____

Name_____ Relationship to patient_____ Phone_____

Name_____ Relationship to patient_____ Phone_____

ALL PATIENTS MUST SIGN

I ACKNOWLEDGE THAT I HAVE RECEIVED AND UNDERSTAND THE KNOLL CLINIC'S NOTICE OF PRIVACY PRACTICES WITH THE EFFECTIVE DATE 09/01/2013.

X_____

_____ _____

Relationship If Not Patient Date

ASSIGNMENT OF BENEFITS: I hereby authorize payment of my medical benefits, including, but not limited to, Medigap benefits, private insurance, Medicaid and any and all other benefits payable by an insurer or other third party to Knoll Clinic LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all records necessary to secure a secure payment. If I am insured by Medicare, I request that payment of authorized Medicare benefits be made on my behalf to Knoll Clinic LLC. for any services provided to me. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be personally responsible for payment of services which are not covered by insurance and further agree to pay collection expenses and attorney's fees necessary to collect payment.

Signature: X_____ **Date:** _____

CONSENT FOR TREATMENT: The following information is to be completed by the patient, or the patient's legally authorized representative/parent.

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand the Knoll Clinic will share patient health information according to federal and state law for treatment, payment, and operations.

Signature: X_____ **Date:** _____

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Patient Name: _____ Birthdate: _____ Date: _____

Reason for Consult: _____

Current Problems: (Circle the following additional symptoms you are currently having)

Back Pain	Fatigue	Night Sweats
Bladder Leakage	Feeling Depressed	Painful Periods
Blood in Urine	Fever	Persistent Cough
Bloody or Black Stools	Nausea/Vomiting	Sexual Difficulty
Breast Concerns: Lump(s) or Discharge	Indigestion	Shortness of Breath
Chest Pains	Frequent Urination	Skin Disorder
Chronic Constipation	Hard to Empty Bladder	Sleeping Problems
Chronic Diarrhea	Headache	Sores on Penis/Vagina
Cold Intolerance or Heat Intolerance	Heart Palpitations	Temporary Loss of Speech
Coughing Up Blood	Joint Pains	Temporary Los of Strength
Difficulty Hearing	Menstrual Problems	Vision Changes
Easy Bruising/Bleeding	Mole Changes	Vision Changes
Excessive Sweating	Nasal Congestion	Weight Gain/Loss
Fainting/Blackout	Nervousness/Anxiety	Wheezing

Other: _____

_____

Past Medical History: _____

Circle or list the past/current medical history:

Abnormal Pap Smear	COPD	Gout	Positive TB Skin Test
Acne	Colon Polyps	Heart Attack	Prostate Problems
Alcohol Abuse	Congestive Heart Failure	Hepatitis	Psoriasis
Anemia	Depression	High Blood Pressure	Reflux/Heartburn
Anorexia/Bulimia	Diabetes	High Cholesterol	Rheumatoid Arthritis
Anxiety Disorder	Diverticulosis/Diverticulitis	Irritable Bowel Syndrome	Rosacea
Asthma	Drug Abuse	Kidney Stones	Seasonal Allergies
Atrial Fibrillation	Emphysema	Kidney Infection/Disease	Seizures
Blood Clot	Eczema	Lupus	Sexually Transmitted Disease
Blood Transfusion	Frequent Bladder Infections	Migraines	Stroke
Chronic Bronchitis/Cough	Frequent Sinus Infections	Osteoarthritis	Tuberculosis
Crohn's Disease	Glaucoma	Osteoporosis	Ulcerative Colitis

Cancer: (please list type) _____

Other Medical problems not on list:

_____

_____

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Have you had SURGERY in the past? YES NO If yes please Circle and list year:

Year:
_____ Appendectomy
_____ Arthroscopy:
(Joint: _____)
_____ Back
_____ Bypass surgery/Heart
_____ Cataract
_____ C-Section
_____ Gallbladder Removal
_____ Hemorrhoids
_____ Hernia
_____ Hip Replacement (LT or RT)

Year:
_____ Hysterectomy (Full or Partial)
_____ Knee Replacement (LT or RT)
_____ Colposcopy/Leep (Cervix)
_____ Mastectomy/Lumpectomy (LT or RT)
_____ Neck Surgery
_____ Polyp Removal
_____ Tonsillectomy
_____ Vasectomy/Tubal Ligation
_____ Plastic Surgery
(List type): _____
_____ Other: _____

Have you ever been hospitalized? **YES NO** **If YES, Reason for Hospitalization:** _____

Are you currently on any medications? **YES** **NO** (If YES, please list all medications)

Drug Name:	Dose:	How Often:	Drug Name:	Dose:	How Often:

Are you allergic to any medications? **YES** **NO** (If YES, please list all allergies and reaction)

Medication:	Reaction:	Medication:	Reaction:	Medication:	Reaction:

Family History: (parents, siblings, grandparents, aunts, uncles, children)

Please circle and list relative and age of onset of conditions:

Heart Attack/Disease _____
Stroke _____
Diabetes _____
High Blood Pressure _____
High Cholesterol _____
Thyroid Disease _____
Depression/Anxiety _____
Other Mental Illness _____
Alcoholism _____

Asthma : _____
Migraines : _____
Cancers (Brain, Breast, Colon, Prostate, Lung, Ovarian, Uterine, Skin, Thyroid and Others)
Please list all family cancer history and age of onset:
_____
_____
_____

Any other illness in family not listed: _____
Has anyone in your immediate family died before the age of 50? **YES NO** If yes, please explain:
_____

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Social History:

Occupation: _____

Marital Status: Single Divorced Separated Married Widowed

Do You Have Any Children? **YES NO** If yes, please list names and ages:

_____

Who Lives with you: _____

Health Habits: please circle yes or no. If yes, please explain:

Do you exercise?	**YES**	**NO**	If so, what type and how often? _____
Do you currently smoke?	**YES**	**NO**	If so, how much? _____ how long? _____
Did you smoke in the past?	**YES**	**NO**	If so, how many yrs? _____ how much?_____ quit date:____
Are you exposed to smoke?	**YES**	**NO**	
Any other tobacco use currently?	**YES**	**NO**	Type: Cigar, Chewing Tobacco, Snuff, Vaping, Other: _____
Any other past tobacco use?	**YES**	**NO**	Type: Cigar, Chewing Tobacco, Snuff, Vaping, Other: _____
Do you drink caffeine?	**YES**	**NO**	If so, how much? _____
Have you ever used street drugs?	**YES**	**NO**	If so, which ones?
			IV Drugs, Cocaine, Heroin, Marijuana, Downers, Inhalants, Others: _____
Are you still using drugs?	**YES**	**NO**	If so, which one(s)? _____
Do you drink alcohol?	**YES**	**NO**	If so, how often: _____
			How many drinks at one time? _____
			Type: Beer, Wine, Hard Liquor, Others: _____
Have you ever had a problem with alcohol in the past?	**YES**	**NO**	
Are you sexually active (in the past yr.)?	**YES**	**NO**	If so, 1 partner, multiple partners, male partners, female partners
Are you currently using birth control?	**YES**	**NO**	If so, condoms, the pill, IUD, or Others: _____
Do you wear sunscreen?	**YES**	**NO**	
Have you had your yearly eye exam?	**YES**	**NO**	
Have you had your yearly dental exam?	**YES**	**NO**	
Do you wear your seatbelt?	**YES**	**NO**	
Do you have a living will?	**YES**	**NO**	
Is there any concern for your safety?	**YES**	**NO**	(emotional, physical, or sexual abuse)

Health Maintenance: Have you ever had the following?

Cholesterol Screening?	**YES**	**NO**	**Results:** _____
Sexually Transmitted Diseases Screening?	**YES**	**NO**	**Results:** _____
Tetanus Shot?	**YES**	**NO**	**Year:** _____
Colon Cancer Screening? (Colonoscopy)	**YES**	**NO**	**Result &Year:** _____
Flu Shot?	**YES**	**NO**	**When:** _____
Pneumonia Vaccine?	**YES**	**NO**	**When:** _____

For Women:

What was the date of your last menstrual period? ____/____/____

How many pregnancies have you had? _____ Birth(s)? _____ Miscarriage(s)?_____ Abortion(s)?_____

Pap smear?	**YES**	**NO**	**Date & Results:** _____
Mammogram?	**YES**	**NO**	**Date & Results:** _____
Bone Density?	**YES**	**NO**	**Date & Results:** _____

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KNOLL CLINIC LLC

NOTICE OF PRIVACY PRACTICES
Effective 9/1/2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is very important to us. We are required by law to:

-Maintain the privacy of your health information
-Give you this Notice of our legal duties and privacy practices
-Follow the terms of this notice

This notice will remain in effect until we revise it. We reserve the right to change our privacy practices and the terms of this notice. Any changes we make will apply to all of the health information about you we maintain. We will make you aware of any changes by:

-Posting the revised notice in our office and/or;
-Making copies of the revised notice available upon your request (either at our office or through the contact person listed in this notice)

WHAT IS HEALTH INFORMATION?

Your health information is information that identifies you and relates to:

-Your past, present, or future physical or mental health or condition
-The treatment we provide to you
-Payment for your past, present or future health care

Your health information includes your name, address, Social Security number and other demographic information. Typically, we keep your health information in our medical and billing records.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Written authorization to release health information is required in the following instances:

-Most uses and disclosures of psychotherapy notes
-Uses and disclosures of protected health information for marketing purposes
-Disclosures that constitute a sale of protected health information
-Other uses and disclosures not described in this notice

How may we disclose your information?

We use your health information to make sure we can appropriately treat you, receive payment for our services and conduct our necessary health care operations. Some examples are:

Treatment: The doctors, nurses, and other staff of Knoll Clinic will use your health information to determine the medical care, tests, procedures and medications you may need. We may disclose your health information to coordinate or manage your health care. For example, we may disclose your information to another health care provider to order a referral, prescriptions, lab work or an x-ray for you.

Appointment: Reminders and Other Contacts: We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.

Payment: We will use your health information to check your eligibility for insurance coverage and prepare a bill to send to you or your insurance company. We will disclose your health information to others to bill and collect payment for our services. For example, in order to bill an insurance company, we will have to disclose information about when you were treated, the conditions you were treated for, and the type of treatment you received.

Health Care Operations: We may use and disclose your health information to allow us to perform functions necessary for our business of health care. For example, within our organization, we may use your information to help us train new staff and conduct quality improvement activities. We may disclose your information to consultants and other business associates who help us with billing, computer and transcription services. In limited situations, we may disclose information to allow other health care organizations to perform their health care operations. For example, we may disclose your information to your insurance company to allow them to conduct quality improvement activities.

Required by Law: We will disclose your health care information when required to do so by law.

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Worker's Compensation: We will disclose your health information to comply with worker's compensation and similar laws that provide benefits for work-related injuries and illnesses.

Public Policy: There are several situations in which the law permits or requires us to use or disclose your health information for public policy purposes. These are:

-Public Health Concerns: We may disclose your health information to public health authorities for certain public health activities such as reporting births or deaths, preventing or controlling disease, and notifying persons who may have been exposed to a disease or may be at risk for spreading a disease.

-Health Oversight Activities: We may disclose your health information to a health oversight agency to conduct audits, investigations, inspections and other activities necessary for the government to appropriately monitor the health care system.

Special Situations: There are some situations that occur rarely, but may require or permit us to use or disclose your health information. These may include:

-Abuse, Neglect or Domestic Violence: We may disclose your health information to the appropriate authorities if necessary to report suspected abuse, neglect or domestic violence.

-Serious Threats to Health or Safety: We may use or disclose your health information when necessary to avert a serious threat to the health or safety of you, another person or the public.

-Organ Donation: We may disclose your health information to an appropriate organization to facilitate organ or tissue donation or transplantation.

-Problems With Products: We may use or disclose your health information to report problems with medical devices or other products that are regulated by the Food and Drug Administration or to allow for product recalls, repairs or replacements.

-Legal Proceedings: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting your information.

-Law Enforcement: We may disclose your health information for law enforcement purposes, as long as we follow specific requirements and restrictions. For example, we may disclose your information to comply with laws that require the reporting of certain types of injuries, to help identify or locate a criminal suspect, or to provide information about the victim of a crime.

-Coroners, Medical Examiners, and Funeral Directors: We may disclose your health information to a coroner, medical examiner or funeral director to allow them to perform their duties.

-Specialized Government Functions: We may disclose your health information as it relates to some specialized government functions, such as military or veterans activities or national security.

-Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your health information to the institution or official as necessary to provide you with health care, protect the health and safety of you or others, and maintain the safety and security of the institution.

When may we make other disclosures of your health information?

For some purposes, we will give you the opportunity to agree or object to a disclosure of your health information. These purposes are:

-Persons Involved In Your Care: If you are present, we may disclose your health information to a relative or other person involved in your treatment or payment for your treatment, but only if you have had an opportunity to agree or object to that disclosure. For example, you may indicate that you don't mind us disclosing your information to a friend or family member by allowing them to join in your meeting with your doctor. If you are not present to agree or object, we will use our professional judgment to determine if disclosing your health information is in your best interests.

-Notifications: We may disclose your location or general condition to notify a family member, personal representative or other person responsible for your care.

If you authorize us to disclose your health information, you may revoke that authorization in writing at any time. If you revoke your authorization we will no longer use or disclose your information for the purposes covered by your authorization. You must understand, however, that we are unable to take back any disclosures we have already made in reliance on your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your health information. We ask that you submit your request to do so in writing. We may charge you a reasonable fee. In some limited circumstances, we may deny you your request to inspect and copy your information.

If that happens, you may ask that the denial be reconsidered. Your request and the denial will then be reviewed by a different licensed health care professional --not the one who originally denied your request. We will comply with the decision that professional makes.

Right to Request Amendment: If you believe that health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You must explain the reasons for your request. We may deny your request if the information you are asking us to change:

-Was not created by us (unless the person that created the information is no longer available to make the amendment)
-Is not part of the health information kept by or for us
-Is not part of the information you are permitted to inspect and copy; or
-Is already accurate and complete

If we deny your request, you have the right to file a statement of disagreement with us. Your statement will be included in any disclosures of your information we make in the future.

Right to Restrict Certain Disclosures to a Health Plan: You have a right to restrict certain protected health information to a health plan where you pay out of pocket in full for the healthcare item or service.

Right to Request Restrictions On Uses and Disclosures of Your Health Information: You have the right to ask us to limit how we use and disclose your health information for your treatment or our payment and business operations purposes. You may also ask that we not disclose your health information to family members or friends involved in your treatment or payment for your treatment.

Right to be Notified of Breach: You have the right to receive a written or verbal notice following a breach of unsecured protected health information

Right to Request Confidential Communication: You have the right to ask us to communicate with you about health matters in a specific way or at a specific location. For example, you may ask that we only contact you at work or by mail. We ask that you make your request for confidential communication in writing. We will comply with reasonable requests.

Right to Opt Out of Fundraising Communications: You have the right to opt out of fundraising communications by submitting a request in writing

Right to Receive an Accounting of Certain Disclosures of Your Health Information We Have Made: You have the right to ask us to give you an accounting of certain disclosures of your health information we may have made. This accounting will not include all disclosures. For example, it will not include disclosures made:

-For your treatment or for payment of your treatment
-For our business operations purposes
-To, or authorized by, you
-To others involved in your care or payment for your care

We ask that you submit a request for an accounting in writing. You may ask for up to six-years of disclosures, but the accounting will not include disclosures made before June 1, 2009. One accounting within any 12 month period will be free of charge. We may charge a reasonable fee for additional accountings, but we notify you of the fee and allow you to withdraw or modify your request before we process it.

You have a right to receive a paper copy of this notice even if you have agreed to receive it electronically.

To exercise any of these rights, please contact Grady Knoll at the following:

Knoll Clinic
1100 E 22nd St.
Hays, Ks 67601

Phone: 785-625-5500
Fax: 785-625-5501

IF YOU HAVE COMPLAINTS OR QUESTIONS

You may send a written request directly to the department of health and human services at:

Office of Civil Rights
Hubert H. Humphrey Bldg.
Room 509F
200 Independence Ave. Southwest
Washington, D.C. 20201