WARD PARKWAY HEALTH SERVICES

8800 State Line Road - Leawood, Kansas 66206-1553
Phone (913) 383-9099 - Fax (913) 213-6026

Joseph W. Barry, M.D.

Stany A. D'Silva, M.D.

Christopher B. Geha, M.D.

Daniel J. Geha, M.D.

Shynda F. Miles, M.D.

David W. Peters, M.D.

Paulette M. Scherrer
Practice Manager

Dear New Patient,

Welcome to Ward Parkway Health Services, Inc. We appreciate your choosing us to participate in your health care. Enclosed are several items that will assist us in providing you with efficient health care.

1). Patient Demographic Information Sheet: **to be completed by patient and returned.**

2). Patient Health History: **to be completed by patient and returned.**

3). Patient Medical Information Authorization: **to be completed by patient and returned.**

4). Notice of Privacy Practices: **patient information only.**

5). Notice of Privacy Practices Patient Acknowledgement: **to be completed by patient and returned.**

6). Medical Records Release of Information: **to be completed by patient and returned.**

Please return completed forms at the time of your visit – or fax – or email to: wphs@wardparkwayhealth.com

FAX #: (913) 213-6026 - OR - (913) 383-9611 - ATTENTION: FRONT DESK

Please bring to your office visit, your current insurance card, driver's license or photo identification, and any medications you are taking in their original containers. We do require that you present your current insurance card at every visit.

Current demographic information helps us help you by timely and correctly filing your insurance claim. A current and thorough health history helps your physician in accurately diagnosing your needs.

We value you as a patient, and appreciate the trust you have placed in us.

Sincerely,

WARD PARKWAY HEALTH SERVICES, INC.

WARD PARKWAY HEALTH SERVICES - PATIENT INFORMATION SHEET

PLEASE PRESENT THIS COMPLETED FORM, YOUR INSURANCE CARD & DRIVER'S LICENSE/OR STATE IDENTIFICATION CARD TO THE RECEPTIONIST - THANK YOU

Today's Date: _____ **Patient e-mail address:** _____

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

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone #: (_____) _____ **Cell Phone #:** (_____) _____

S.S.#: _____ **Date of Birth:** _____ **Sex:** _____

Patient's Employer: _____ **Occupation:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone #: (_____) _____ **Job Title:** _____

Marital Status: (Please circle one) Married Single Divorced Widowed

Policy Holder (Please circle one) Self Spouse Parent Other: _____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Policy Holder's Employer: _____ **Policy Holder's Cell Phone:** _____

***Referring* Physician:** _____ **Physician: (To send reports)** _____

Emergency Information: Individual(s) to notify in case of emergency

Name: _____ **Relationship:** _____

#1 - Phone #: (_____) _____ **#2 - Phone #:** (_____) _____

Name: _____ **Relationship:** _____

#1 - Phone #: (_____) _____ **#2 - Phone #:** (_____) _____

Pharmacy Name: _____ **Pharmacy Phone #:** _____

_____ _____

Pharmacy Address/Location **Pharmacy Fax Number**

I authorize Ward Parkway Health Services to furnish my insurance carriers and other providers involved in my care the necessary medical information concerning my illness or injury. I also authorize payment directly to the physician providing services for medical benefits. I understand that I am financially responsible for all charges whether or not covered by insurance.

SIGNED: _____ **DATE:** _____

(PATIENT OR AUTHORIZED PERSON'S SIGNATURE)

MEDICARE LIFETIME CONSENT:

I request that payment of authorized Medicare benefits be made on my behalf to my designated physician for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

NAME OF BENEFICIARY (PATIENT): _____ **DATE:** _____

First Name: _____ Last Name: _____

Date of Birth: _____ Referring Physician: _____

Allergies to medications, x-ray dyes, or other substances: _____

_____

Medications (please list medicines you are taking now or within past month)

Name	Dosage (mg)	Frequency	Name	Dosage (mg)	Frequency

Have you taken cortisone-type drugs? _____

Family History	Living	Present age/age at death	Significant health problems or cause of death
Father	Y N		
Mother	Y N		
Spouse	Y N		
Present marriage (years)			Previous marriage(s) (years)
Brothers	# living		Significant health problems
	# dead		Cause(s) of death
Sisters	# living		Significant health problems
	# dead		Cause(s) of death
Children	# living		Significant health problems
	# dead		Cause(s) of death

Please circle illnesses which have occurred in any of your blood relatives:

Bleeding tendency	Diabetes	High blood pressure	Nervous disease	Tuberculosis
Cancer _____	Heart Disease	Kidney Disease	Stroke	Arthritis

Please circle illnesses or conditions which you have had:

Bleeding tendency	Vein trouble	Seizure	Asthma	Rheumatic Fever
Cancer	Heart Disease	Nervous Disorder	Jaundice	Glaucoma
Diabetes	Pneumonia	High Blood Pressure	Hepatitis	Gonorrhea
Thyroid Disease	Stroke	Tuberculosis	Kidney Disease	HIV
Osteomyelitis	Meningitis	Other: _____		

Previous operations (please list procedure and year)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Tobacco use Never Now in the past How many per day? _____ For how many years? _____

Alcohol use Never Now in the past How many per day? _____ For how many years? _____

Please circle and list year of diseases against which you have been immunized:

Tetanus _____ Pneumonia _____ Influenza _____ Hepatitis B _____ Hepatitis A _____ Meningococcal _____

Measles (Rubeola) _____ German Measles (Rubella) _____ Polio _____ Rabies _____ Japanese encephalitis _____

Typhoid _____ Yellow Fever _____ Haemophilus (HIB) _____

Have you lived or traveled outside the US or Canada? _____ Where: _____ Year: _____

Do you have any pets? _____ If yes, please list: _____

Have you ever received a blood transfusion? Y N When: _____

Have you ever donated blood? Y N When: _____

Have you ever had a Tuberculosis skin test? Y N When: _____ Was it positive? Y N

Have you ever been tested for Hepatitis B? Y N When: _____ Was it positive? Y N

Have you ever been tested for Hepatitis C? Y N When: _____ Was it positive? Y N

Have you ever been tested for HIV? Y N When: _____ Was it positive? Y N

Women Only- Last menstrual period? _____ Your last Pap Smear? _____

Number of pregnancies? _____ Number of miscarriages? _____

What is your main medical problem now, and how long have you had it?

_____

_____

_____

_____

_____

_____

POS Reorder # 1603624

WARD PARKWAY HEALTH SERVICES

PATIENT NAME (PLEASE PRINT): _____ **DOB:** _____

Our policy concerning Doctor/Patient confidentiality is such that our staff will not discuss information regarding a patient without specific written authorization from the patient.

MEDICAL INFORMATION AUTHORIZATION

You are hereby authorized to furnish any or all medical information concerning my physical condition treatment and/or test results to the following individuals.

NAME	RELATIONSHIP

_____ _____

PATIENT SIGNATURE **DATE**

I do not wish any medical information concerning my physical condition, treatment and/or test results to be released at any time to anyone other than myself.

_____ _____

PATIENT SIGNATURE **DATE**

POS Reorder # 1603625

WARD PARKWAY HEALTH SERVICES, INC.
8800 STATE LINE ROAD
LEAWOOD, KANSAS 66206-1553
PHONE: (913) 383-9099

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Ward Parkway Health Services, Inc. may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Ward Parkway Health Services, Inc. has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Ward Parkway Health Services, Inc. will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Ward Parkway Health Services, Inc. to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Ward Parkway Health Services, Inc. has taken action relying on this consent.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____ _____

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revision of our *'Notice'* at any time by contacting: Ward Parkway Health Services, Inc. (913) 383-9099 or email: wphs@wardparkwayhealth.com.

POS Reorder # 1603626

MEDICAL RECORD RELEASE OF INFORMATION

Patient Name: _____ **S.S. #:** _____

Date of Birth: _____ **Telephone #:** _____

Address: _____

Address: _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below:
The following individual or organization is authorized to make the disclosure:

Physician/Clinic Name: _____
Address: _____
City, State, Zip Code: _____

Phone #: _____ Fax #: _____

The type and amount of information to be used or disclosed is as follows:
Two (2) years back with most recent test results
Five (5) years back with most recent test results Specific information _____

RESTRICTIONS: This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following individual or organization:

To Release to: **WARD PARKWAY HEALTH SERVICES**

Street Address: **8800 STATE LINE ROAD**

City, State, Zip: **LEAWOOD, KANSAS 66206-1553**

Fax number #: **(913) 213-6026**

Phone number #: **(913) 383-9099**
For the purpose of: Medical evaluation and/or treatment

- ☐ **Joseph W. Barry, M.D.**
- ☐ **Stany A. D'Silva, M.D.**
- ☐ **Christopher B. Geha, M.D.**
- ☐ **Daniel J. Geha, M.D.**
- ☐ **Shynda F. Miles, M.D.**
- ☐ **David W. Peters, M.D.**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the authorization.

_____ _____
(Date) **(Signature of Patient)**

_____ _____
(Witness) **(Signature of Parent, guardian or authorized representative)**

***If signed by a patient's authorized representative:** _____ _____
***Printed name of authorized representative** ***Relationship/Capacity to patient**

_____
***Address and telephone number of authorized representative**

disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Privacy Officer, 8800 State Line Rd., Leawood, KS 66206. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Privacy Officer, 8800 State Line Rd., Leawood, KS 66206.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Privacy Officer, 8800 State Line Rd., Leawood, KS 66206.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Privacy Officer, 8800 State Line Rd., Leawood, KS 66206. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Privacy Officer, 8800 State Line Rd., Leawood, KS 66206. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.northlandent.com. To obtain a paper copy of this notice, Privacy Officer, 8800 State Line Rd., Leawood, KS 66206.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Privacy Officer, 913-383-9099. All complaints must be made in writing. You will not be penalized for filing a complaint.

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.

NOTICE OF PRIVACY PRACTICES

Ward Parkway Health Services, Inc.

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Privacy Officer, 8800 State Line Rd., Leawood, KS 66206.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose 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 an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer