Heart of Kansas Family Health Care, Inc.
Registration and Disclosure Information

Patient Name _____ Patient DOB _____

Responsible Party _____ Resp. Party DOB_____

Read and Initial lines 1-6 then sign below

— **1. Demographics and Responsible Party**
I certify that the demographic, insurance, and income information I have provided today date is true and accurate.

— **2. Acknowledgement of Receipt of Notice of Privacy Practices**
I have received the Notice of Privacy Practices from Heart of Kansas Family Health Care, Inc. today.

— **3. Assignment of Benefits**
I authorize Patient's insurance company to pay benefits for services to patient to Heart of Kansas Family Health Care, Inc. I understand that I am responsible for payment of Patient's deductible and any unpaid balance incurred.

— **4. Disclosure of Information**
I authorize Heart of Kansas Family Health Care, Inc. to disclose any of Patient's protected health information to Patient's insurance company needed to determine payment of services rendered to Patient. This authorization expires upon the date of expressed termination of ongoing medical care and treatment by Patient by Heart of Kansas Family Health Care, Inc. and may be revoked at any time by Patient, or their responsible party, by a writing provided to Heart of Kansas Family Health Care, Inc., except when disallowed as provided in the Notice of Privacy Practices. Heart of Kansas Family Health Care, Inc. may not condition treatment based on the refusal to provide such authorization.

— **5. Consent to Medical Care**
I consent to the performance of examination, treatment, laboratory tests, and medical procedures determined to be necessary for the Patient's health and welfare by the medical personnel of Heart of Kansas Family Health Care.

— **6. Household Assessment**
I certify that the following people are immediate family members who live in my household
The household street address is: _____
The household PO box is: _____
City _____ State _____ Zip _____+_____

Full Legal Name	Date of Birth	Relationship to responsible party

Patient Signature _____ **Date** _____

If the patient is a minor, I certify that I am the parent or legal guardian of this patient, and attest to each of the above statements on his/her behalf:

Parent/Guardian Signature: _____ **Date** _____

Witness signature _____ **Date** _____

Responsible Party _____ **Date** _____