South Central
Kansas Specialty Clinic
A subsidiary of South Central Kansas Medical Center
6403 Patterson Pkwy Arkansas City, KS 67005 620.441.5711
www.sckmc.org/specialtyclinic

The Specialty Clinic at
South Central Kansas Medical Center
Clinic of Suhail Ansari, MD
NO SHOW POLICY

This notice is to inform you of the recent changes in the Specialty Clinic, No Show Policy, including the clinic office of Suhail Ansari, MD.

Below is an outline of the No Show Policy, effective February 1, 2021:

1. If a patient is more than 30 minutes late for their appointment (other than coming from imaging), they will be considered a no show for the appointment.
2. If a patient fails to call and cancel or reschedule their appointment prior to 4 business hours before the scheduled appointment time, they will be considered a no show.
3. There will be one (1) courtesy No Show Letter sent to the patient for the first No Show appointment.
4. After the first no show letter, the patient will be charged a $20.00 no show fee on their account to be paid before the next appointment. This fee will not be billed through insurance and is the patient's responsibility.
5. After 3 no shows the patient would be recommended for dismissal from the Specialty Clinic, Orthopedic office of Suhail Ansari, MD.

I acknowledge that I have received a copy of this policy.

_____ _____

Patient Signature Date

SCK HEALTH

Winfield Medical Arts	South Central Kansas Clinic	SCKC Primary Care	SCKC Specialty Clinic	SCK Midwives

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Dear Patient,

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the 2013 HIPAA Omnibus Rule, we are required to provide you with a copy of our privacy practices regarding health information. We are also required to make a good faith effort to obtain your signed acknowledgement that you have received a copy of our privacy practices. Please indicate your acknowledgement of these practices by signing below. Thank you.

My signature below indicates that I have received/declined a copy of the Notice of Privacy Practices.

_____ _____

Printed Name Relationship to Patient (if signed by legal representative)

_____ _____

Patient Name (if different than above) Patient's Date of Birth

_____

Signature of Patient or Legal Representative Date

****This is a permanent part of this patient's medical record and shall be retained within the chart. If the records are thinned, this form remain a part of the primary record.****

Office Use Only:

Patient Received Notice and declined to acknowledge receipt at this time.

_____ _____

Date Employee Signature

SCK HEALTH

Winfield Medical Arts	South Central Kansas Clinic	SCKC Primary Care	SCKC Specialty Clinic	SCK Midwives

AUTHORIZATION TO TREAT MINOR CHILD WHEN NOT ACCOMPANIED BY GUARDIAN/PARENT

The clinic must have permission from a child's legal guardian/parent before providing medical care when someone other than the legal guardian accompanies the child. This form will be retained into your child's record.

Name of Patient:_____ Date of Birth:_____

I,_____, give the following person(s) permission to bring my child to the clinic to receive medical treatment and to make medical decisions and rights to confidential information during my absence.

***The following persons will have my permission to authorize medical care for my child and sign any needed form(s) signifying my responsibility for payment.

Name	Relationship	Phone Number

Parent/Guardian Signature:_____Date:_____

Witness Signature:_____Date:_____

THIS AURTHORIZATION WILL REMAIN IN EFFECT UNTIL CHANGED BY THE PARENT OR LEGAL GUARDING SIGNED ABOVE.

SCK HEALTH

Winfield Medical Arts	South Central Kansas Clinic	SCKC Primary Care	SCKC Specialty Clinic	SCK Midwives

Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with SCK Health Clinics. This form when signed, allows SCK Health Clinics to communicate with the authorized person about your personal information concerning insurance benefits, payments, treatment, or any other health care information regarding your care.

_____ _____ _____ ____/____/_____ _____

First Name M Last Name DOB SSN#

I hereby give my consent for SCK Health Clinics to communicate personal information on my behalf to the authorized person(s) named below. I may revoke this authorization at any time in writing to SCK Health Clinics P.O. Box 1107 Arkansas City, Kansas 67005. This authorization allows SCK Health Clinic's staff to speak with the authorized person(s) regarding: Treatment, insurance, benefits, copays, or any other aspects regarding care. This form **does not** allow access to the patient's medical record. This form **excludes** any communication on patients that are in a confidential status.

Signature: _____ Date: _____ Time: _____

Person(s) Authorized to speak with SCK Health Clinics

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Witness: _____ Date: _____ Time: _____

This consent remains in effect until it is revoked in writing from the patient or legal representative.

SCK HEALTH

Winfield Medical Arts	South Central Kansas Clinic	SCKC Primary Care	SCKC Specialty Clinic	SCK Midwives

FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we contract with, full payment maybe expected at each visit. If you are insured by a plan we contract with, but don't have a current insurance card, payment in full may be required until we can verify your coverage. Every health insurance policy is different. It is your responsibility to become familiar with your own policy. Please contact you insurance company with any questions you may have regarding your coverage.

2. **Co-Payments and Deductibles.** All copayments and Deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit and keeping your account current.

3. **No Insurance.** If you do not have insurance, payment in full is expected after each visit. We do offer discounted fees for patients without medical insurance.

4. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payments for all services.

5. **Proof of insurance.** All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license or identification card and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

6. **Claim submission.** We will submit claims to your health insurance company and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request(s). Please be aware that the balance of your claim(s) is your responsibility regardless if your insurance company pays or denies your claim(s). You insurance benefits is a contract between you and your insurance company, we are not a party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment.** Patients with delinquent accounts are required to make payment in full for future services. Partial payment will not be accepted. Some accounts may be eligible for resolution with a payment plan. If a payment plan is negotiated, timely payments per the plan are required. New reminders will not be sent on such accounts. If a payment is missed, the account will automatically be referred to collections. Patients with accounts that have been referred to collections will be required to setup and keep a payment arrangement with the Collection Agency or pay balance due in full in order to maintain a relationship with the clinic. Patients with collection accounts may be discharged from our practice along with family members they are guarantor of. A patient who is discharged will be notified by certified mail.

9. **Missed appointments.** Broken appointments, "No Shows", represent a cost to us and to other patients who could have been seen in the time set aside for you. A 24 hour notice is required for any cancellation. We reserve the right to charge $20.00 for late cancellations or no show appointments. The no show fee cannot be billed to your insurance company; you are directly responsible for payment on or before your next appointment. Three (3) no show appointments are considered chronic and the patient may be discharged from the practice for failed professional relationship. Please help us service your better by keeping your regularly scheduled appointments.

10. **Medication refills.** Monitor your medication usage and plan your monthly follow-up visits if you need refills. No refills will be given if appointments are missed. Refill requests require 48 hour notice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

For Office Use Only

Copy Given Copy Not Given

Accepted by:_____

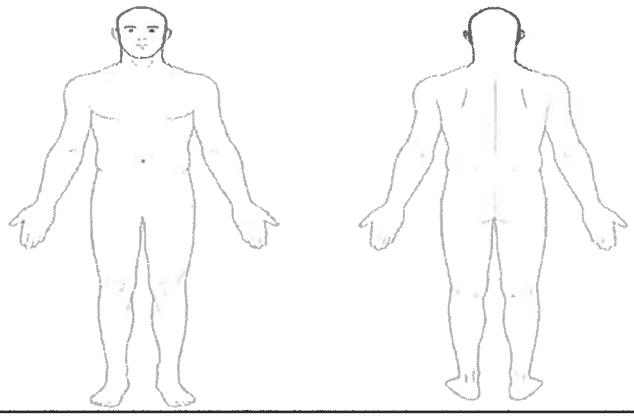
Initial Health History

General Information	
Name: _____	**DOB:**_____ **Date:**_____
Primary Care Physician:_____	**Referring Physician:**_____
Cardiologist:_____	**Any other physician you see:**_____
Date of last F/U:_____	_____
Preferred Pharmacy:_____	**What are you being seen for:**_____

Pain Description

Place the appropriate letter on the diagram

numbness = **n** tingling = **t** aching = **a** stabbing = **s** buringing = **b** weakness = **w**



Rate your Daily Average Pain

0 1 2 3 4 5 6 7 8 9 10

Is this pain due to an injury? ___Yes ___No If yes, how did the injury occur?_____

When did your symptoms begin? Month_____ Year_____ _____

Do you feel your pain is getting _____Better _____Worse _____Unchanged

Which of the following activites makes your pain worse? (Circle all that apply)

Walking Standing Sitting All Physical Activities

Which of the following activites makes your pain better? (Circle all that apply)

Walking Standing Sitting All Physical Activities Medication Other_____

Conservative Treatment	Beneficial	Name of Facility	Date of Last Visit
Physical Therapy	Y N		
Injections	Y N		
Chiropractic	Y N		
Medications (pain, muscle relaxers)	Y N		
Other:_____	Y N		

Fall Risk	
Have you fallen in the past 12 months?	Y N
Were you injured in the fall?	Y N
Have you fallen more than once in the past 12 months with or without injury?	Y N

Medical History (check all that apply)

- Abnormal Heart Rhythm
- Anemia
- Aneurysm
- Anxiety
- Arthritis
- Asthma
- Bipolar Disorder
- Bleeding/Clotting Disorder
- Cancer:_____
- Carotid Artery Disease
- Chest Pain
- COPD
- Congestive Heart Failure
- Depression
- Dementia
- Dabetes Mellitus
- Emphsema
- Enlarged Prstate (BPH)
- Epilepsy
- Gallbladder Disease
- GERD (acid reflux)
- Gout
- Heart Attack (MI)
- Heart Disease (CAD)
- Heart Valve Problems
- Hepatities
- HIV
- High Cholesterol
- High Blood Pressure
- Hyperthyroidism
- Hypothyroidism
- Inflammatory Bowel Disease
- Intestinal Problems
- Kidney Disease
- Kidney Disease
- Kidney Stones
- Liver Disease
- Mental Illness
- Migraine/Headaches
- Multiple Sclerosis
- Open Wounds: __Past __Current: Location:_____
- Pneumonia
- Peripheral Vascular Disease
- Sexually Trasmitted Disease
- Sleep Apnea
- Stomach Ulcers
- Stroke/TIA
- Tuberculosis
- Other:_____

Surgical History (check all that apply)

- AAA Repair
- Arthroscopy
- Appendectomy
- Back Surgery
- Bariatric Surgery (Weight Loss)
- Breast
- Cardiac Surgery
- Carotid Endarterectomy
- Carpal Tunnel Release
- Eye Surgery
- Colon/intestinal
- Gallbladder
- Hernia Repair
  Type:_____
- Heart Cath
  Date:_____
- Hysterectomy
- Neck Surgery
- Orthopaedic Surgery
  - Hip
  - Knee
  - Lower Ext
  - Upper Ext
  - Shoulder
  - Neck
  - Back
- Skin Cancer Excision
- Prostate Surgery
- Thyroid Surgery
- Upper Endoscopy
- Colonoscopy date:_____
- Other:_____

Social History

Exercise Level
- None
- Occasional
- Moderate
- Heavy

General Stress Level
- Low
- Medium
- High

Children
Total #:_____

Living Status
- Alone
- With Others

w/whom:_____

Marital Status
- Single
- Married
- Divorced
- Seperated
- Engaged
- Widow

Currently Employed
- No
- Yes

Where:_____

Job Requirments:_____

Max Lifting Capability

Tobacco Use
- Never
- Current/Former

quit date:_____
- Chewing Tobacco
- E-Cigs
- Other:_____

Education Level
- Less than High School
- High School Graduate
- College

Drug Use
- Never
- Drug Abuse History

Type:_____
- Current Drug Use

Type:_____

Medications (name and dosage)		

Allergies

Please list with reaction:_____

_____

_____

Any previous issues with anesthesia: No Yes (please explain):_____

_____

Family History

☐ I do not know my family history

☐ Family history of issues with anesthesia

Mother ☐ Alive ☐ Deceased	☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer (type)_____ ☐ Other_____
Father ☐ Alive ☐ Deceased	☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer (type)_____ ☐ Other_____
Sister(s) #_____ ☐ Alive ☐ Deceased	☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer (type)_____ ☐ Other_____
Brother(s) #_____ ☐ Alive ☐ Deceased	☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer (type)_____ ☐ Other_____

Review of Sysytems (check all that apply)

General History
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue

Ear/Nose/Throat
- ☐ Hoarseness
- ☐ Choking
- ☐ Sinus Drainage
- ☐ Sore Throat

Neurologic
- ☐ Muscle Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Memory Loss

Respiratory
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Recent Infection

Cardiac
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Swollen Feet
- ☐ Stress Test

  Date:_____

Musculoskeletal
- ☐ Neck Pain
- ☐ Joint pain/swelling
- ☐ Back Pain
- ☐ History of Factures
- ☐ Muscle Pain
- ☐ Muscle Cramps

Genitourinary
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence

Endocrine
- ☐ Hormone Problem
- ☐ Execessive Thirst
- ☐ Hot/Cold Intolerance
- ☐ Neck Mass

Hematologic
- ☐ Slow wound Healing
- ☐ Easy Bruising/Bleeding
- ☐ Anemia
- ☐ Enlarged Glands
- ☐ Varicose Veins

Dermatologic
- ☐ Recent changes in mole
- ☐ Rashes
- ☐ Masses Below Skin
- ☐ Lesions That Bleed
- ☐ Lesions That don't Heal
- ☐ Skin Tags
- ☐ Itchy Skin Lesion

Gastrointestinal
- ☐ Heart burn
- ☐ Difficulty Swallowing
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Rectal Bleeding
- ☐ Dark Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in Stools
- ☐ Scar Pain/Bulge
- ☐ Groin Pain/Bulge