Bradley Freilich M.D.
Paresh Patel, M.D.
Janay Kissinger, ANP
Office: 816-361-0055

KCGI
Kansas City Gastroenterology & Hepatology, LLC

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip:_____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Choose not to disclose

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Mandarin ☐ Other:_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:_-_____-_____Phone number: _____
Address:_____City_____, State_____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Insurance plan: _____ Subscriber No. _____

Group No. _____Payer ID _____

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____(First) _____
Phone number:_____Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
_____ City, State:_____ZIP: _____
Home phone:_____Work phone:_____Ext. _____

PRIMARY CARE PROVIDER

Primary Care Provider Name: (Last)_____(First) _____
Phone number:_____
Address_____ City, State:_____ZIP: _____

PHARMACY

Pharmacy Name: _____Pharmacy Phone:_____
Pharmacy Address:_____ City, State:_____ZIP: _____

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PAST MEDICAL HISTORY

What medications or supplements are you taking? ___ None (okay to attach list)

Medication **Dosage** **Frequency**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any drug allergies? ____ No ____ Yes (If yes please list below along with reaction)

Allergy **Reaction**

_____
_____
_____
_____
_____

Social History

Marital status: ____ Single ____Married _____ Separated ____ Divorced ____ Widowed

Smoking status: ____ Never smoker ____Former smoker Year Quit _____ ____ Current smoker Packs per day ____
_____ Smokeless tobacco

Alcohol: Do you drink alcohol ___ Yes ____ No If yes Drinks per week _____

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General Consent for Care and Treatment

_____ (**Patient/Representative initials)** TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

_____ (**Patient/Representative initials)** If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.
Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details). This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.
A photocopy of this consent shall be considered as valid as the original.

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Communications about My Healthcare

_____ (**Patient/Representative initials)** I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ (**Patient/Representative initials)** I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Release of Information.

_____ (**Patient/Representative initials)** I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

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Financial Policy

_____ (**Patient/Representative initials)** Thank you for choosing KCGI as your choice for your healthcare needs. Our goals are to provide you with excellent care, minimize your out-of-pocket expenses, and make paying your balance as easy as possible. Our financial department is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

Insurance: For the convenience of the patient, we will file medical claims with your insurance plans with which we have an agreement if valid insurance information is provided to us. Please be prepared to bring your insurance cards and photo identification to each appointment. If this is not provided, you will run the risk of having your appointment rescheduled or will need to pay at the time of service.

The patient is responsible for notifying our office of any insurance changes prior to any scheduled appointments. Insurance policies are an agreement between the patient and his or her insurance company. All account balances are the responsibility of the patient. Payment is due from the patient upon receipt of the first statement from our office.

The patient is expected to know his or her insurance benefits to include copays, deductible, and co-insurance. Copays are due at the time of service. If the patient does not have medical insurance, or if KCGI providers are not participating with his or her insurance carrier, all charges incurred during treatment are due and payable at the time of service. Self-Pay patients are required to pay at time of service unless a payment arrangement was set up prior to your appointment.

We understand that situations arise that require you to cancel your appointment. Therefore, if you must cancel your office visit appointment, please provide more than 48-hour notice. If you are scheduled for a procedure and need to cancel this appointment, please provide 14 business days or more notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than these time frames, we are unable to offer that slot to other patients.

Office appointments that are canceled with less than 48 business hours' notice may be subject to a $75 Cancellation fee. Procedure appointments that are canceled with less than 14 business day notice may be subject to a $250 cancelation fee.

Patients who do not come to their scheduled appointment without a call to cancel the appointment will be considered a No Show. Patients who No Show two (2) or more times in a 12-month period may be dismissed from the practice and denied any future appointments. Patients may also be subject to a $75 No Show fee for office visits and $250 No Show fee for procedures. The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

ALL CHECKS RETURNED FOR NON-SUFFICIENT FUNDS WILL BE ASSESSED A $50.00 CHARGE.

REFERRALS/AUTHORIZATIONS: It is the responsibility of the patient to obtain a referral from his or her primary care provider prior to your scheduled appointment. If a referral is required by insurance to obtain services provided by a specialty provider. If a referral is not obtained, the patient accepts full financial responsibility for all services provided.

_____ _____

Patient Name (Please Print) **Date of Birth**

_____ _____

Signature of Patient (Patient Representative) **Date**

Updated 08/22/2024

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Section A: This section must be completed for all Authorizations

Patient Name:	Birth Date:	Last Four Digits SSN. *(optional):*
Provider's Name: Bradley L Freilich MD	Recipient's Name:	Kansas City Research Institute
Provider's Address: 6675 Holmes Rd Ste 430	Address: 6675 Holmes Rd Ste 430	
	City: Kansas City	State: MO Zip: 64131

Request Delivery (If left blank, a paper copy will be provided):		Paper Copy	Email		Electronic Media, if available (e.g., USB drive, CD/DVD)

Email Address (If email checked above. Please print legibly):

Purpose of Disclosure: To provide Kansas City Research Institute a copy of (and/or allow ongoing electronic access to) my medical record so that they may evaluate the feasibility of research studies (including clinical trials) and contact me should I qualify for one or more of their studies.

Description of information to be used or disclosed

Is this a request for psychotherapy notes?	Yes, then this is the only item you may request on this authorization. You must submit another - authorization for other items below.
X	No, then you may check as many items below as you need.

	Description:	Date(s):		Description:	Date(s):		Description:	Date(s):
X	All PHI in medical record			Operative Information			Labor/delivery sum.	
	Admission form			Cath lab			OB nursing assess	
	Dictation reports			Special test/therapy			Postpartum flow sheet	
	Physician orders			Rhythm Strips			Itemized bill:	
	Intake/outtake			Nursing Information			UB-92:	
	Clinical Test			Transfer forms			Other:	
	Medication sheets			ER Information			Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information psychiatric, HIV testing, HIV results or AIDS information. (Initial) _____

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a healthplan or health care provider, the released information may no longer be protected by federal
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it, upon request.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☒ Yes ☐ No
If yes, describe: Kansas City Research Institute will be paid by research sponsors.
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient: