SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

## PATIENT INFORMATION

| | |
|---|---|
| Social Security Number: | Employer: |
| Name: | Employer Address: |
| Address: | Employer City: |
| City: | Employer State: Zip: |
| State: Zip: | Email: |
| Home Phone Number: | Referring Provider: |
| Work Phone Number: | Primary Care Provider: |
| Cell Phone Number: | Marital Status: |
| Sex: | Employment: FT / PT / Self / Military / Unemployed / Retired |
| Date of Birth: | Student Status: FT / PT / Not a student |
| Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Declined | Preferred Language: |
| Ethnicity: Hispanic or Latino / Refused / Not Hispanic or Latino | Preferred Hospital: |

## DISCLOSURE

I understand that it is my right to elect to whom my medical, insurance and/or financial information can be released. For our records the first person listed will be your emergency contact. I also understand that if I choose to leave this information blank, the facility will not have an emergency contact or be able to release any information to anyone, including my spouse/significant other, children, parents, siblings, etc. I therefore authorize KUSM-W Medical Practice Associate to release my information as directed below.

| | | |
|---|---|---|
| Name: | Relationship: | Phone: |
| Name: | Relationship: | Phone: |

## AUTHORIZATION

I do hereby authorize the release of any medical information necessary to process claims on my behalf. I request that all insurance benefits be paid directly to KUSM-W Medical Practice Association for all charges incurred by me. I understand that I am responsible for all charges incurred during my treatment at KUSM-W Medical Practice Association Clinics regardless of insurance coverage. I agree to pay the entire balance of my account in a timely manner.

_____ _____

Responsible Party Signature Date

## MPA NOTICE OF PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of the Medical Practice Association's Notice of Privacy Practices

Patient Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Patient received a copy of the MPA Notice of Privacy Practice and refused to acknowledge receipt at this time

Employee Signature: _____ Date: _____