MANHATTAN PRIMARY CARE

Bradley K. Harrison MD, FAAFP | Kyle E. Platz DO, FAAFP | Kerri M. Maxcy, PA-C

Patient Name:_____ DOB:_____ SSN:_____
Last First MI MM/DD/YYYY

Patient Information	Responsible Party
Address:_____ Address 2: _____ City:_____ State:_____ Zip:_____ Phone (home): (____)____-_____ Phone (work): (____)____-_____ Extension:_____ Phone (cell): (____)____-_____ Preferred Name (Alias): _____ E-mail Address: _____	□ Self □ Name_____ □ Same Contact Information as Patient Address:_____ Address 2: _____ City:_____ State:_____ Zip:_____ Phone (home): (____)____-_____ Phone (work): (____)____-_____ Extension:_____ Phone (cell): (____)____-_____ Relationship to Patient:_____

Race	**Ethnicity**	**Primary Language**	**Marital Status**	**Gender**
□ Asian □ Black/African American □ White □ Prefer not to disclose □ Other_____	□ Hispanic/Latino □ Not Hispanic/Latino □ Prefer not to disclose	□ English □ Other _____	□ Single □ Married	□ Male □ Female

Primary Insurance:	**Secondary Insurance:**
Insurance Provider:_____ Effective Date:_____ □ Check here if the patient is the policy holder. If not, please provide the information below. Policy Holder:_____ Policy Holder DOB:_____ Policy Holder Relationship to Patient: _____	Insurance Provider:_____ Effective Date:_____ □ Check here if the patient is the policy holder. If not, please provide the information below. Policy Holder:_____ Policy Holder DOB:_____ Policy Holder Relationship to Patient: _____

Emergency Contact
Name:_____ Phone Number: (____)____-_____ Relationship: _____

I authorize Manhattan Primary Care to correspond with me via email that is not encrypted (secure)? ☐ Yes ☐ No

Please Initial:

_____ I have been given the opportunity to read the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ I authorize verbal discussion of my care with _____.
Name DOB Relationship

_____ I authorize Manhattan Primary Care to leave non-sensitive health information messages at the following number(s): (____)____-_____(____)____-_____(____)____-_____

_____ I have read, understand, and agree to the Financial Policy outlined by Manhattan Primary Care (MPC).

_____ I have been given the opportunity to read the vaccine policy outlined by Manhattan Primary Care.

Patient/Parent/Guardian Signature:_____ Date:_____

Parent/Guardian Name: _____

1133 College Ave, Bldg A, Ste A211 | Manhattan, KS 66502
Phone 785-320-5000 | Fax 888-524-2251
www.ManhattanKSPrimaryCare.com

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Patient Name:_____ **Date of Birth**: _____
Family member(s) current patient at MPC:_____ Preferred Pharmacy: _____
Occupation/Employer:_____ Job Title: _____

Social History

Tobacco Use : □Current □Previous □Never How many pack/day_____# of years smoking_____
Alcohol Use: □ No □ Less than 5 drinks weekly □ Greater than 5 drinks weekly □ Greater than 10 drinks weekly
Children: □ Yes □ No If yes, (#____Ages_____) Children's physicians: _____
Are you, or is there a chance you may be pregnant: □ Yes □ No If yes, how far along: _____

Family Health History

Father: □ Living □ Deceased: Age: ___ Medical Problems: _____
Mother: □ Living □ Deceased: Age: ___ Medical Problems: _____
Brother: □ Living □ Deceased: Age: ___ Medical Problems: _____
Sister: □ Living □ Deceased: Age: ___ Medical Problems: _____

Health Maintenance

Vaccine:	Date:	Vaccines:	Date:	Exam:	Date:	Exam:	Date:
Pertussis (Tdap)	_____	Shingles	_____	Colonoscopy	_____	Bone Density	_____
Pneumonia	_____	Influenza	_____	Mammogram	_____	Pap Smear	_____

Past Medical History

□ CVA (stroke)/TIA
□ Seizure/Epilepsy
□ Headaches
□ Coronary Artery Disease
□ Congestive Heart Failure
□ Abnormal Heart Rhythm
□ High Blood Pressure
□ High Cholesterol
□ Blood Clots/DVT
□ IBS
□ Acid reflux
□ Asthma
□ COPD/Emphysema
□ Sleep Apnea
□ Osteoporosis
□ Fibromyalgia
□ Diabetes
□ Thyroid Disease
□ Kidney Disease
□ Anxiety/Depression
□ Cancer: _____
□ Other: _____
□ Other: _____

Do you currently have any of these symptoms?

□ Chills
□ Fever
□ Significant weight change
□ Headache
□ Blurred vision
□ Chest pain
□ Palpitations
□ Swelling of extremities
□ Abdominal pain
□ Heartburn
□ Fainting
□ Anxiety
□ Depression
□ Appetite changes
□ Abnormal bleeding

Surgical History

Type of Surgery / Reason:	Year:

Medication Allergies:

Name of Medication/Product:	Reaction:

Medications/Supplements/Birth Control

Medications:	Strength:	Frequency:	Medication:	Strength:	Frequency:

Other Providers You See:

	Specialty:

Most Recent Primary Care Physician: _____

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Manhattan Primary Care Payment Policy (Update 1/12/2021)

Thank you for choosing Manhattan Primary Care (MPC) as your primary health care provider. We are committed to providing you with quality and affordable health care. If you have any questions about our payment policy, please let us know.

1. **Insurance.** All co-payments and deductibles must be paid at the time of service. Please be aware that someor all the provided services may be non-covered or not considered reasonable or necessary by insurers. Please contact your insurance company with any questions you may have regarding your coverage. Any amount not covered by insurance, including non-covered services, co-payments, and deductibles, will be your financial responsibility. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your photo ID and current valid insurance card(s) to provide proof of insurance. New patients will require photo ID. Active insurance card is required at every visit.

2. **Claims submission.** Manhattan Primary Care (MPC) contracts with California Healthcare Medical Billing (CHMB) to submit your claims and assist you in any reasonable way to help get your claims paid. Your insurance company may need you to supply certain information directly. If your insurance claim is denied by your insurance, you will receive two statements to notify you that your claim has not been paid. Please contact us directly at 785-320-5000 immediately to resolve the billing issue. If you have not received a bill from Manhattan Primary Care within 60 days of your appointment, please call MPC to ensure your information is being processed correctly by your insurance.

3. **Uninsured or Cash Payment**. If you do not have your current insurance card at the time of service, you will be treated as a cash payment patient. If you are paying as a cash pay patient, we will require a deposit before your appointment. If you choose to pay in full the day of service, you will receive a discount, otherwise, you will be billed for the full remainder.

4. **Payment.** We accept cash, check, debit and credit cards. We will send two bills to collect payment due after your insurance is processed. If you cannot pay your bill in full, please contact MPC to set up a formal payment plan. If there is no payment or payment plan arranged on the account, we will refer your account to a collection agency. If you have a balance and are being seen in clinic, you will be expected to pay on your account at the time of appointment. If you owe under $75, you will be expected to pay in full. If you owe over $75, you will be required to pay $75 towards your balance and sign a bi-weekly payment plan form with arrangements to pay off balance in 2 months. If you cannot pay as described, you will be asked to reschedule non-emergent appointments. If your appointment is missed due to nonpayment, you will be counted as no show. If a payment plan is over 30 days without a payment, the full balance will be referred to a collection agency. If you pay by check and your check is returned by your bank, your account will be charged $30 and you will be required to pay with cash or credit card going forward. Any unpaid balance requiring outside collections efforts will be assessed a collections fee.

5. **Insurance and address changes.** If your insurance changes, please notify us before your next visit. If your address or phone number changes, please contact MPC to update your information to complete your billing process.

6. **Missed appointments or cancellation.** Patients who miss an appointment are notified via email or mail. The charges are missed appointments or same day cancellation for established patients are as follows: 1st $0, 2nd $0, 3rd and beyond $100. These charges will be your responsibility and billed directly to you. If you have three no shows, you may be dismissed from the practice.

7. **Dismissed patients.** If you are discharged from the practice for nonpayment, returned checks, missed appointments or behavior, your immediate family members may be discharged from this practice. MPC will notify you by regular mail and certified mail that you have 30 days to find alternative medical care. Thirty days after notification is attempted, no further appointments or refills be allowed.

8. **Collections.** If you or an immediate family member is referred to collections, the collection balance must be paid in full before routine appointments can be booked. Any patient with a balance greater than 90 days old and/or sent to collections will be required to keep an active credit card on file to be billed for future charges. At discretion of provider, refill requests may not be granted for patients who have balances greater than 90 days old.

9. **Refunds.** After insurance and all private payments have been made to an account and there is a credit balance left that is due to the patient, a check will be made out to the patient/guarantor. Manhattan Primary Care will not write a check for any amount under $5.00 unless requested.

10. **BCBS/Cigna Specialist Copay Adjustment.** MPC may choose to adjust off a portion of a patient's copay when commercial insurance coverage is Cigna or an out of state Blue Cross Blue Shield plan that considers a Physician's Assistant a 'specialist' and therefore requires a specialist copay for a visit with Kerri Maxcy, PA at MPC. The amount that may be adjusted is that which exceeds the plan's copay for an office visit with a primary care physician.

Payment Policy Updates. Every patient must update patient information sheet at the first visit of each calendar year. Payment policy updates will be posted on our website.

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Manhattan Primary Care Vaccine Policy Statement

Vaccines have been proven to be effective in preventing serious illness and death related to certain diseases. All children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics. The recommended vaccines and the schedule given are the results of years of scientific study and data gathering by thousands of scientists and physicians. Deviation from the standard vaccine schedule goes against our medical advice as providers at Manhattan Primary Care. If you are considering a vaccine schedule that is different from the standard schedule, you would need to discuss this with your child's physician.

We will no longer accept the risk that unimmunized or under-immunized children or teens pose to other children and their families in our practice and in our communities. If, despite our best efforts, a child remains unimmunized or under-immunized, we will ask you to find another provider who shares your views on immunizations. We are happy to provide education and recommended resources for further information about vaccinating your child.

All children must receive all vaccines recommended by the AAP that are mandated for school entry by the State of Kansas. All children must begin receiving their immunizations by age 2 months. We strongly recommend utilizing the immunization schedule as determined by the AAP, ACIP and CDC. "Alternative" vaccine schedules put children and adults at an increased risk of illness. There is no medical benefit whatsoever to delaying vaccines. Manhattan Primary Care will accept delays of vaccine administration only if they are within the "window" period of the recommendations of AAP, ACIP and CDC. If a parent or caregiver elects to limit their child to 2 vaccines at a time, they must come into the office at 1-2 week intervals to stay within the recommended "window" for the vaccines. If a parent or caregiver elects to limit their child to 1 vaccine at a time, they must come into the office at weekly intervals to stay within the recommended "window" for the vaccines.

If we are not approved by your insurance to give vaccines, the schedule must be maintained at an alternative location, such as the Riley County Health Department. Families who do not follow the Manhattan Primary Care vaccine policy will need to find another physician to care for their child. We will care for your child for 30 days while you make this transition. Our providers welcome discussion about our vaccine policy with any of our families.

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Notice of Privacy Practices

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
Manhattan Primary Care
Phone 785-320-5000

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you.
You have the right to:

- request restrictions on specific uses and disclosures of your information as provided by 45 CFR 164.522(a), but we are not required to agree to a requested restriction
- obtain a paper copy of the notice of health information privacy practices upon request
- access, inspect and obtain a copy of PHI on paper, including right to have electronic copies
- amend your health record as provided in 45 CFR 164.526
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request confidential communications of your health by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- forward e-copies to 3rd party
- control PHI use for marketing, sales, research
- be notified of breach of PHI
- file a complaint.

Our Responsibilities

The organization is required by law to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice on the Manhattan Primary Care website at ManhattanKSPrimaryCare.com.

We will not use or disclose your health information without your written authorization, except as described in this notice. You may revoke such authorization at any time in writing.

For More Information or to Report a Problem

If you have questions or would like additional information, you may contact the Privacy Officer/ Director of Health Information Management at 785-320-5000. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer/ Director of Health Information Management at 785-320-5000 or with the Region VII Office of Civil Rights in Kansas City; Regional Manager Office for Civil Rights; U.S. Department of Health and Human Services; 601 East 12th Street – Room 248 Kansas City, Missouri 64106; Voice Phone (816)426-7278; Fax (816)426-3686; TDD (816)426-7065 or: Secretary of Health and Human Services; 200 Independence Avenue, S.W. Room 515F HHH Bldg.; Washington D.C. 20201 or https:www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

Examples of Use and Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your medical provider will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the medical provider will know how you are responding to treatment.

We will also provide your medical provider or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you if you are referred elsewhere for further treatment.

We will use your health information for payment: A bill may be sent to you or a third-party payer (i.e. insurance company). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointment Reminders and Treatment Follow up: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care at Manhattan Primary Care or regarding follow up of a previous appointment. Unless you direct us to do otherwise, we may leave messages on your telephone answering machine identifying Manhattan Primary Care and asking for you to return our call. Unless we are specifically instructed by you to otherwise in a particular circumstance, we will not disclose any health information to any person other than you who answers your phone except to leave a message for you to return the call.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in radiology, certain laboratory tests, and a records storage company we use for storing copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your case. Any further disclosure would require a signed authorization from you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Surveys: We may contact you to complete a patient satisfaction survey following a visit to the health center.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or similar programs established by law.

Employer: We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury.

Public Health: As required by law: we will disclose medical information about you when required to do so by federal, state, or local law. We may use and disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Updated Oct 28, 2020