Patient Registration

*Fields marked with * are required*

Today's Date*: _____

Patient Information

Patient Name: First*: _____MI: _____ Last*: _____ Preferred Name: _____

Physical Address Street*: _____City*: _____State*: _____Zip*: _____

Mailing Address Street: _____ City: _____State: _____Zip: _____
(Please leave blank if same as physical address)

Date of birth*: _____ Social Security #: _____ Sex*: _____ Marital Status: _____

Preferred Contact Method(s)*: ☐ Home ☐ Work ☐ Cell ☐ (SMS)Text ☐ E-mail *(select all that apply)*

Primary Phone*: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

Alternate Phone: _____ ☐ Home ☐ Work ☐ Cell

Alternate Phone: _____ ☐ Home ☐ Work ☐ Cell

E-mail Address: _____ Alternate E-mail Address: _____

Other Patient Information

Primary Care Provider*: _____ Phone: _____

Referring Provider *(if applicable)*: _____ Phone: _____

Select all additional services that apply to the patient*: ☐ Home health ☐ Hospice ☐ Skilled nursing ☐ Assisted Living ☐ None

If Yes...Name of facility/provider: _____ Room # *(if applicable)*: _____

Emergency Contact Information *(please provide two contacts with different contact information)*

Contact 1:

First Name*: _____ Last Name*: _____Relationship to Patient*: _____

Primary Phone*: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

Contact 2:

First Name: _____ Last Name: _____Relationship to Patient: _____

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

Responsible Party

Choose one*: ☐ Self ☐ Parent/Guardian ☐ Other _____

(If the patient is the responsible party, this section may be left blank.)

First Name*: _____MI: _____ Last Name*: _____ Date of Birth*: _____

Primary Phone*: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

E-Mail Address: _____

Physical Address Street*: _____ City*: _____State*: _____Zip*: _____
(if different from patient)

Mailing Address Street:_____ City: _____State: _____Zip: _____
(if different from patient or physical address)

Patient Insurance Information

☐ Not Applicable; I am a self-pay patient

Primary Insurance Information:

Insurance Company Name*: _____ Patient ID#*: _____

(The policyholder is the individual who owns or provides the insurance policy, whether obtained through an employer, the health insurance marketplace, an individual plan, or a government program.)

Choose one*: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other _____

Policy Holder Full Name*: _____ Date of Birth*: _____
(if different from patient)

Secondary Insurance Information:

Insurance Company Name: _____ Patient ID#: _____

(The policyholder is the individual who owns or provides the insurance policy, whether obtained through an employer, the health insurance marketplace, an individual plan, or a government program.)

Choose one: ☐ Self ☐ Parent/Guardian ☐ Spouse ☐ Other _____

Policy Holder Full Name: _____ Date of Birth: _____
(if different from patient)

Appointment Checklist

- **Verify Appointment Information**
  Patients are advised to verify appointment times and office locations prior to arrival, as the practice operates at multiple locations. Patients who arrive more than 15 minutes late for a scheduled appointment may be required to reschedule. No-Show appointments may result in a fee.
- **Valid Identification and Current Insurance Cards**
  Patients are required to present valid identification and current insurance cards at each appointment. Such documentation may be requested by staff at any time. Failure to present required documentation upon request may result in delays, rescheduling, or extended wait times.
- **Expected Payments**
  Any expected payments, including but not limited to copayments, deposits, or payment of outstanding balances, are due at the time of service.
- **Insurance Referrals**
  A copy of any required insurance referral must be provided at the time of the appointment if mandated by the patient's insurance plan.
- **Medication List and Medical Records**
  Patients should bring a current list of medications and any relevant medical records related to their visit.
- **Assistive Items or Support Person**
  Patients are encouraged (sometimes required) to bring a support person and any necessary assistive devices, including eyewear or hearing aids, as needed.

Authorizations and Consents

Notice to Patients: *Midwest Medical Specialists is a multi-specialty practice. To provide coordinated care and ensure every patient receives consistent information, we have consolidated all authorizations and consents for services provided by our practice. Although your appointment may not include every service listed on these documents, completing this consent process helps reduce duplication of paperwork and supports the efficient delivery of care.*

NOTICE OF PRIVACY PRACTICES

Midwest Medical Specialists is committed to protecting your privacy. Our HIPAA Privacy Notice explains how your personal health information may be used, disclosed, and protected, as well as how you can access this information. Please review it carefully.

Please use one of the following methods to obtain a copy for your review:

Online: https://www.midwestmedicalspecialists.com/images/Forms/Notice_of_Privacy_Practices.pdf

Posted: Copies are posted at the front desk of each location.

Printed or Electronic: Upon request, we are happy to provide you with a paper or electronic copy.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that Midwest Medical Specialists, P.A., may use or disclose all or any part of my medical record for purposes of payment, treatment or healthcare operations as described in the Midwest Medical Specialists, P.A., Notice of Privacy Practices. My initials here and signature/esignature at the end of this packet acknowledge that a copy of this Notice was made available to me prior to signing this document.

☐

Initials*

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, AND RELEASE OF MEDICAL INFORMATION

I hereby authorize treatment deemed necessary by Midwest Medical Specialist's providers. I am fully responsible for payment of all services provided by Midwest Medical Specialists, P.A. I assign and grant to Midwest Medical Specialists all my rights, title and interest in and to any insurance benefit otherwise payable to me by reason of receipt of services from Midwest Medical Specialists, P.A. I request that all payments and benefits should be made directly to Midwest Medical Specialists on my behalf for services rendered to me by said party. I understand that I am fully responsible for all amounts not covered by insurance. My initials here and signature/esignature at the end of this packet acknowledge that I agree and understand.

☐

Initials*

IN-OFFICE ENDOSCOPY CONSENT FORM – For ENT Patients

During your office visit, your provider may determine based on your symptoms, physical exam and/or history that an in-office procedure called endoscopy (scope) is medically necessary. This procedure provides valuable clinical information when there may be a condition or disease in the nose or throat that is not adequately visualized on routine examination. I understand that declining this procedure may lead to an incorrect or lack of diagnosis which may adversely impact my treatment and outcome. I understand the risks associated with refusing this procedure.

The procedure is done using a fiber optic or rigid endoscope. After nasal spray is used to shrink and numb the nasal membranes, the scope is passed through the nose, so structures in the nose, mouth, and throat can be directly observed. Complications associated with this procedure are rare but may include sneezing, coughing, gagging, bleeding, and/or minor discomfort.

Please note that endoscopy is considered by the American Medical Association (AMA) to be a surgical procedure and is billed according to AMA guidelines. The procedure will be listed as a separate charge from your office visit and is subject to your medical plan guidelines on deductible, coinsurance and/or copay. If you have any questions, please do not hesitate to contact our billing staff. They can be reached directly at (816) 454-5603.

Rigid Scope

Flexible Fiberoptic Scope

My initials here and signature/esignature at the end of this packet acknowledge that I understand the benefits and risks of the procedure(s) as explained above. I understand that I have the right to decline endoscopy at the time of my visit.

Initials*

MIDWEST MEDICAL SPECIALISTS, P.A. FINANCIAL POLICY

We are committed to providing you with exceptional care. We value our relationship with our patients and wish to inform you of our financial policies regarding your responsibilities for the services provided by our office.

- **INSURANCE** – You are responsible for understanding the details of your insurance coverage. Our office will bill all contracted insurance plans directly; however, patients must provide accurate and complete insurance and billing information at the time of service. Our office requires identity to be verified for all patients that are utilizing health insurance. Failure to present accurate insurance information at the time of the appointment may result in rescheduling or payment of services in full. You are responsible for confirming that the providers you see are in-network with your insurance plan. Regardless of insurance coverage, you remain responsible for payment of your account. In cases where patients elect to pay out-of-pocket rather than use insurance, payment in full is required at the time of service. Depending on network participation status, a signed waiver may be required.
- **COPAYS, DEDUCTIBLES, CO-INSURANCE** – All copays are expected at the time of service. To make payment arrangements for your copay **prior** to your visit, please contact our Billing Department at 816-454-5603. If you arrive for your appointment and are unable to pay your copay, you will be asked to reschedule for a later date. Outstanding account balances are due in full upon check-in. If you are unable to make payment in full, you will be asked to speak with a member of our billing office to discuss payment options. Responsibility for payment of non-covered services, cosmetic services, and products/supplies rests with the patient and will be collected at the time of service. Accepted forms of payment include cash, check, CareCredit, Apple Pay, Samsung Pay, Visa, MasterCard, Discover, American Express, money order, and cashier check.
- **REFERRALS** – If your insurance plan requires a referral to see a specialist, it is your responsibility to obtain the completed referral form and present it at the time of the visit. You must also confirm with your insurance provider whether the referral needs to be on file with them. Failure to provide the required referral may result in rescheduling the appointment or payment of services in full. You are responsible for knowing if your insurance plan requires a referral.
- **PRE-PAYMENT** – Some procedures and surgeries may require prior payment when not fully covered by insurance.
- **IN OFFICE PROCEDURES** – You may have a procedure done in office that your insurance considers to be an in office surgical procedure. These procedures are separate from your office visit and may be applied to your deductible or have a co-pay applied to them. You are responsible for these services unless you have declined to have the procedure done at the time of service.
- **PATHOLOGY/CULTURES** – You are responsible for informing us if your insurance requires a specific lab to be utilized for pathology/cultures. Specimens submitted for analysis are a separate service and billed by the laboratory in question. If you do not request a specific lab at the time of service, we will send your specimen to one of our preferred labs.
- **PREVENTIVE SKIN SCREENINGS** – Our Dermatology providers are happy to see you for an exam; however, because skin screenings are not recommended in the U.S Preventive Services Task Force guidelines, we are unable to submit claims for preventive skin screenings to your insurance as a “no cost” benefit under the Affordable Care Act.
- **SELF-PAY** – Payment is due in full at time of service. A 50% Time of Service (TOS) discount is offered to patients that are uninsured, have limited coverage/policy exclusions, or have out-of-network insurance (some restrictions may apply). A $100 deposit toward your visit is due upon check-in. At the time of check-out, we will review the provider’s notes and verify all services/procedures that were performed. Any remaining balance due will be collected at this time. In the event that we are unable to provide you with a final expected balance, we will apply your $100 deposit to the pending charges, and the remaining balance will be billed to you. If unable to pay the full amount requested

at the time of service, you must contact the billing office for payment arrangements within 24 hours to avoid forfeiting any TOS discount. If the final balance is unable to be provided to you at time of check-out, you must pay the remaining balance in full upon receipt of the first statement. If the account remains unpaid after 30 days, the TOS discount will be forfeited, and the full charge amount will be due. If you have participating coverage but elect to self-pay, payment is due in full at the time of service and a waiver must be signed. Medicaid recipients cannot be seen as self-pay. If you purposely misrepresent yourself as a self-pay/uninsured patient and coverage is later discovered, we are not obligated to retroactively submit said claims to Medicaid.

- **PAYMENT ARRANGEMENTS/FINANCIAL ASSISTANCE** – Payment arrangements and/or financial assistance may be available under certain circumstances. For additional information, please contact our billing office at (816) 454-5603. Any payment arrangements made must remain in good standing. Failure to maintain the arrangement may result in restrictions on future appointments and the outstanding balance being referred to an external collection agency.
- **MINORS/DEPENDENTS** – The parent or legal guardian who signs consent for treatment on behalf of a minor child or legal dependent will be considered the **"Responsible Party"** and will be financially responsible for the patient. Our office does not become involved in child custody disputes or determine custodial rights.
- **PAST DUE ACCOUNTS/COLLECTIONS** – If a balance remains unpaid after 60 days, it is considered past due. Past due balances may result in restrictions on your account and may prevent you from scheduling future appointments until the balance is resolved. We reserve the right to refer past due accounts to a collection agency. Should your account be turned over to a collection agency, you will be responsible for all fees associated with attempting to collect the balance due. Any balance referred to collections must be paid in full prior to scheduling future appointments.
- **RETURNED CHECKS** – There is a $25.00 fee for all returned checks.
- **NO SHOW/CANCELLATION POLICY** – There may be a $50 fee for no show appointments and/or cancellation of appointments without 24 hour notice. Repeat occurrences may result in suspension or dismissal from the practice.
- **COMMUNICATIONS** – I consent to receive communications from Midwest Medical Specialists, P.A. at the phone number(s) I provided upon registration, including my wireless number (if provided). This consent extends to communications by organizations that the office may contract with to manage and/or collect for services provided. I understand I am responsible for any charges to my wireless number by my wireless carrier. Some calls may be generated by an automated dialing system and may include pre-recorded messages. (The receipt of healthcare services is not conditioned upon my agreement to be contacted by phone as described in this section.)

My initials here and signature/esignature at the end of this packet acknowledge that I have reviewed and understand the Financial Policy of Midwest Medical Specialists, P.A. and agree to its terms.

☐

Initials*

For more billing information and a list of frequently asked questions, please visit: https://www.midwestmedicalspecialists.com/billing-center

---

I acknowledge that I have reviewed and agree to the above policies of Midwest Medical Specialists, P.A. I certify that the information I have provided is complete and accurate. I further understand that by signing/e-signing below, I agree to comply with the policies described herein.

_____ _____

Patient/Responsible Party Signature* Date*