K. Dean Reeves M.D.

4740 El Monte St – Roeland Park, KS 66205
Phone- (913) 362–1600   Fax- (913) 362-4452

PATIENT INFORMATION

Date: ____________________

Legal Name:

____
Dr/Mr/Mrs/Ms/Miss   First   Middle   Last   Suffix

Nickname: _____________ Date of Birth:_________ Age:______ Sex: M or F (please circle)

____
Street Address   City   State   Zip

________________________ ________________________ ________________________
Home Phone   Cell Phone   Work Phone
❑ Voice messages OK   ❑ Text messages OK   ❑ Voice messages OK
❑ Voice messages OK

____
Email Address

____   ____________________________
Employer   Occupation/Job

_______________________ ______________________ ____________________________
Emergency Contact   Relationship   Emergency Phone

Primary Care Physician_________________________________

Who may we thank for referring you to our practice? ______________________________

HIPAA/Privacy Release Authorization

I, ______________________________, hereby give permission for K. Dean Reeves M.D. and office staff to discuss my medical condition and care &/or billing information with the following person(s):

__________________________ ________________ ________________________

Name Relationship Phone Number

□ Authorized to discuss MEDICAL CONDITION AND CARE
□ Authorized to discuss BILLING INFORMATION

__________________________ ________________ ________________________

Name Relationship Phone Number

□ Authorized to discuss MEDICAL CONDITION AND CARE
□ Authorized to discuss BILLING INFORMATION

I have been informed of the Privacy Practices and Patient Bill of Rights and have received a copy from Dr. Reeves' website or in Dr. Reeves' office.

____ ______________________

Signature of Patient or Patient Representative Date

COMMUNICATION CONSENT FORM

____
Patient Name

Patient Portal (Choose only ONE option)

- ☐ **I DO** want to have access to my patient information on the patient portal. Please use this email to set up access:____

- ☐ **I DO NOT** want to have access to my patient portal.

Emails (Choose only ONE option)

- ☐ **I DO** consent to email communication from Dr. Reeves and his office staff for direct communication but **NOT** for medical records. Please use this email:____
  PLEASE DO NOT EMAIL MY MEDICAL RECORDS.
  I understand that emails will not be encrypted.

- ☐ **I DO** consent to email communication from Dr. Reeves and his office staff for direct communication **-AND-** for my medical records when I specifically request them. Please use this email:__________________________________

  They **will not** be automatically emailed to me.
  I understand that emails will not be encrypted.

- ☐ **I DO NOT** consent to email communication of any kind. **I prefer regular mail or phone only.**

____ _________________
Signature of Patient or Patient Representative Date

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AUTHORIZATIONS and FINANCIAL POLICY

Thank you for choosing the office of K. Dean Reeves, MD. We strive to provide the very best care and to do so we would like to take this opportunity to acquaint you with our office policies. Please read over the following information. In addition, we suggest you review your health insurance policy and familiarize yourself with the coverage it provides.

Costs & Payment Due at the Time of Service

I understand that I am financially responsible for all charges arising from my own or my dependents evaluation, follow up visit or any other billable procedure. Prolotherapy, Perineural Injection and PRP are not covered my any insurance. I am responsible to pay for these procedures at the time of service. I understand that if I am delinquent and default on the terms of this agreement then my account will be closed and I will no longer be able to schedule any other appointments until my bill is paid in full.

Appointments/Cancellations

This office only sees an average of 4 patients a day and allows 2+ hours for initial evaluations. Unexpected cancellations will idle our staff for a major portion of the day, and we will be unable to see others who need an appointment. This makes patient communication regarding scheduling changes critical to our office. Please give notice at least 10 days prior to your scheduled appointment or a cancellation fee may apply.

- If a cancellation has occurred with less than 24 hours notice, any rescheduling will be at the discretion of Dr. K. Dean Reeves, MD.
- I understand that if I arrive late for an appointment I may be asked to reschedule my appointment.

Minor Patients (Patients under age 18)

Any patient under the age of 18 must be accompanied by a parent/guardian to each visit, unless otherwise specified by K. Dean Reeves, MD. I understand by signing KDRMD's financial policy, I am solely responsible for any incurred charges for the below named patient. Patients under the age of 18 may not cancel or change an appointment in this office.

Returned Check Fee

I understand that if K. Dean Reeves, MD receives a returned check I will be charged an additional $25 above the amount on the check and will be on a cash only basis thereafter.

Reinstatement

I understand that if my account is closed with K. Dean Reeves, MD, it will be at management's discretion to accept me back into the practice. If accepted back I know I am responsible to have my balance paid in full before having any future treatments with K. Dean Reeves, MD. I also understand that there will be a minimum of a $25.00 charge for reinstatement fee applied to my account. The reinstatement fee and the full amount of the next visit are due at that time of service.

Patient Name (Printed) ________________________________

____ ______________
Signature of Patient or Patient Representative Date

____ ______________
Guardian/Responsible Party Date

____ ______________
Office Witness Date