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

____
Email Address

____ _____________________________
Employer Occupation/Job

________________________ _______________________ _____________________________
Emergency Contact Relationship Emergency Phone

Primary Care Physician__________________________________

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

BILLING INFORMATION

Health Insurance Company: ____
ID # __________________________ Group # ___________________________
Secondary Insurance: ____
ID # __________________________ Group # ___________________________

Other If Applicable (circle type): Work Comp Auto Accident

Please fill out all applicable information below:

Insurance Company: _____________ Phone Number: _____________________
Address: ______________________ Date of accident: ____________________
Claim Number: _________________ Adjuster's Name: ___________________
Adjuster's Phone Number: ____________________

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

Health Insurance Portability and Accountability Act Waiver (HIPAA)

Because Dr. Reeves' office is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, appointment times, prescriptions, or any information contained in your records with us. Please list any persons (and relationship) or agencies that we have your permission to release your information to. This information can be amended by you as needed.

Name:_________________________Relationship:______________________
Name:_________________________Relationship:______________________
Name:_________________________Relationship:______________________
Name:_________________________Relationship:______________________

Messages:

I give my consent to Dr. Reeves and staff at Dr. Reeves' office to leave messages or discuss scheduling, treatment, or other information regarding my care as follows:

- ☐ On my answering machine or voice mail at **home**
- ☐ On my answering machine or voice mail at **work**
- ☐ On my **cell phone**
- ☐ On my **email** (for direct communication with Dr. Reeves)
- ☐ I **do not** consent to messages being left at **home, work, email, or with any other person**.

____ _______________________

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 in order to do so we would like to take this opportunity to acquaint you with our office policies. Please take a few moments to read over the following information. In addition, we suggest you review your health insurance policy and familiarize yourself with the coverage it provides.

Insurance and Driver's License due at time of service

I understand that in order for K. Dean Reeves, MD to file insurance claims on my behalf, I must present proper proof of insurance at the time of my appointment. K. Dean Reeves MD accepts several insurance plans and every plan is different. It is up to the insured to know the exact requirements of their own insurance plan. INSURANCE WILL NOT BE FILED WITHOUT A COPY OF THE INSURANCE CARD.

Assignment of Insurance Benefits

I hereby authorize and assign, my insurance carrier(s), to make payment directly to K. Dean Reeves, MD of insurance benefits for services herein specified and otherwise payable to the insured. K. Dean Reeves, MD files both primary and secondary insurance as a courtesy to patients. I understand and agree that I am financially responsible to K. Dean Reeves, MD for all charges incurred regardless of potential insurance benefits. I understand K. Dean Reeves, MD will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company that K. Dean Reeves, MD, the physician treating me is covered under my insurance and to get referrals and /or authorization for services.

Costs & Payment 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 in all contracts. 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.

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.

Referral Forms

I understand that if I have an HMO or PPO insurance requiring a referral; a completed referral form or referral number from my primary care physician (PCP) must be provided at the time of my appointment. I understand that failure to provide referral information at the time of my visit

will necessitate either rescheduling my appointment, or payment in full at the time of the service.

Appointments

This office only sees an average of 4 patients a day and allows 2 hours or more 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 might be requesting a sooner appointment. This makes communication by the patient for changes in scheduling very important for our office.

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.

Patient Name (Printed) ___________________________________

____ _______________

Signature of Patient or Patient Representative Date

____ _______________

Guardian/Responsible Party Date

____

Office Witness