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: ___________________________