M-Care
HEALTHCARE FOR EVERYONE

(316) 461-0339 phone
(316) 221-1000 fax

Registration

This information is collected for demographic purposes and will not affect your care. Medical records are confidential and protected under Kansas law. Your written consent will be required for release of information except in case of a court order.	
Date of Birth ____/____/____ (month/day/year)	Today's Date ____/____/____
Name Used (last, first, middle initial)	Social Security Number
Pronouns	Gender
Reason for Care? (select all that apply) ☐ Gender Affirming Care ☐ Gynecological Care Primary Care ☐ Primary Care/ Management of Chronic Conditions (please list) ____________________________________	
Legal Name* (last, first, middle initial)	*M-Care recognizes the validity of all genders / sexes. Unfortunately, many insurance companies and legal entities do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and legal correspondence.
Sex Listed on Insurance* (check one) ☐ Male ☐ Female	
Are you transgender? ☐ Yes ☐ No ☐ Questioning	What sex was assigned to you at birth?
How do you define your sexuality?	
How do you define your relationship status?	
How do you define your race & ethnicity?	
How did you find M-Care Healthcare?	

Your answers to these questions will help us reach you quickly and discreetly with important information.			
Home Phone ( )	Cell Phone ( )	Other Phone ( )	Best Number to use: ☐ Home ☐ Cell ☐ Other
OK to leave voicemail? ☐ Yes, simple* ☐ Yes, detailed** ☐ No	OK to leave voicemail? ☐ Yes, simple* ☐ Yes, detailed** ☐ No	OK to leave voicemail? ☐ Yes, simple* ☐ Yes, detailed** ☐ No	*Simple messages will ask for a return call to our office only. **Detailed messages may contain personal health information such as lab results or recommended treatments and should only be left on a secure, personal line.
Address	City	State	ZIP
Email address			
Do you consent for automated appointment reminders and/or messaging to the preferred phone number and email listed above? **Do you consent to your email address to be used to access the patient portal?** ☐ **YES** ☐ **NO**			
Emergency Contacts Name	Phone Number		Relationship to you
1.			
2.			

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Health History

Name ____ DOB _____________________________

Medical History			
Acid Reflux (GERD)	Crohn's or Colitis	Hepatitis (type: _A _B _C)	Osteopenia/Osteoporosis
ADHD	Chronic Pain	High Cholesterol	PTSD
Allergies	COPD	HIV	Rheumatoid Disease
Anemia	Depression	Hypertension	Schizophrenia
Anxiety	Deficiency of Vitamin	Hyperthyroid	Self Harm
Arthritis	Diabetes Type 1 or Type 2	Hypothyroid	Skin Problems
Asthma	Elevated Hemoglobin	Impaired Senses	Sleep Apnea
Autism	Fibromyalgia	Insomnia	Syphilis
Bipolar Disorder	Genital Herpes	Irritable Bowel Syndrome	Trichomonas
BPD	Genital Warts	Kidney Disease	Ulcers
Bladder Problems	Gonorhea	Leg Swelling	OTHER:
Blood Clotting Problems	Gout	Migraines	
Cancer ____________	Heart Disease	Multiple Sclerosis	
Chlamydia	Heart Rhythm Problems	OCD	
Social History			
Alcohol Use	Current or Daily Use	Former User	Social or Occasional Use
Drug Use _______________	Current or Daily Use	Former User	Social or Occasional Use
Tobacco Use	Current or Daily Use	Former User	Social or Occasional Use
Gynecological History	# of Pregnancies	# of Live Births	# of living children
Abortion	Endometriosis	Infertility	Ovarian Cysts
Abnormal PAP Smear	Heavy Periods	Irregular Periods	Pelvic Inflammatory Disease
Chronic Pelvic Pain	High Risk HPV	Miscarriage	PCOS

Surgical History		please note the year (or years) that the procedure was done	
Appendix Removal	Cervical LEEP	Kidney Surgery	Tonsils/Adenoids Removed
Back Surgery	D&C	Mastectomy R L B	Tubal Ligation
Breast Augmentation	Gallbladder Removal	Oophrectomy R L B	Tubes in Ears
Breast Reduction	Gastric Bypass or Sleeve	Rhinoplasty	Vasectomy
Cesarean Section	Hernia Repain	Sinus Surgery	Wisdom Tooth Extraction
Cervical Colposcopy	Hysterectomy	Thyroid Surgery	OTHER:
Gender Affirming Surgeries			
Chest Masculinization	Metoidoplasty	Phalloplasty	Voice Surgery
Facial Feminization	Orchiectomy	Vaginoplasty	Vulvoplasty

Medications		please include all prescription and over the counter medication	
Medication	Dose/Strength	# of pills per dose	Times per day

Allergies	please include all food or drug allergies
Allergy	Reaction

Preferred Pharmacy	please include name and address

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Insurance & Billing

Name ____ DOB ______________________________

Please answer these questions even if you plan to pay cash today.		
Insurance Company Name	Insurance Policy Name	
ID/Policy #	Group #	
Policy Effective Date	Co-Payment	Co-Insurance or Deductible
Employer/School Name	Address City	State Zip
If you are covered under someone else's insurance policy, please complete the following:		
Primary Subscriber's Name	Primary Subscriber's SS#	Relationship to You
Primary Subscriber's Employer	Name Address	Primary Subscriber Phone ( )

Authorization and Assignment of Insurance Benefits/Release of Medical Information: I authorize and request my insurance company to pay benefits directly to M-Care Healthcare for services rendered. I authorize the release of any medical records and/or other information required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including, if applicable, my employer, employer's workman's compensation insurance company, the Social Security Administration and/or the Centers for Medicare & Medicaid Services, needed to determine benefits, process insurance claims, and secure payments of benefits to either the insured or to M-Care Healthcare. Additionally, I will submit fully completed claim forms as requested by my insurer or M-Care Healthcare.

Referrals and Authorizations: If I have an insurance plan that requires any referrals, pre-certifications and/or authorizations, I understand that it is my responsibility to obtain approval from my insurer for medical services prior to services being rendered by notifying my PCP of my request and providing all required documentation. If any medical services are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible, and that any of these aforementioned actions do not guarantee that my insurer will pay for the claims. Any denial of claims is between the policy holder and my insurer. I understand medical services may not be rendered without the proper referral on file.

Financial Agreement: I agree that payment in full is due at the time of treatment. I understand that if my insurer refuses to cover any or all charges for services provided, that I am responsible for and agree to pay any all charges denied by my insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the policyholder and the insurer. Any assistance in these matters granted by M-Care Healthcare is given strictly as a courtesy and implies no responsibility on M-Care Healthcare's part for filing, follow through, or confirmation. I agree that if for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fee(s) for service(s). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service, and/or any other reasons, I agree to pay all charges within 30 days of services rendered. I understand Fenway Health reserves the right to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify credit bureaus of my delinquencies.

Certification: I certify the information I provided above is true and complete. I agree to inform M-Care Healthcare immediately of a change in insurance coverage, benefits, or personal information. I permit a copy of this authorization and signature to be used in place of this original on all insurance claim and submissions, whether manual, electronic, or telephonic. I understand and agree that the terms herein are reaffirmed each time services are rendered.

Patient Signature: _______________________________________ Date: _________________________________
Print Name: _____________________________ Legal Name (if different): ________________________________

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Consent to Treat

Name ____ DOB ________________________________

Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. Informed consent is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

I hereby give my consent and authorize M-Care Healthcare, LLC to treat any medical or mental health condition providing that the care provider has explained all of the following to me- 1. My condition or medical diagnosis 2. The recommended treatments or procedures 3. Any alternative methods of treating my condition or medical diagnosis 4. Any foreseeable risks of the treatment or procedure 5. The possibility that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously.

I understand that M-Care Healthcare, LLC operates a primary care practice that believes in caring for the mental and physical health of all of our patients. M-Care Healthcare, LLC views behavioral and mental health services as an important aspect of physical health and valuable to overall well-being. I agree that, when appropriately recommended by my primary care provider, I will seek behavioral health services. I understand that, in rare cases, medical treatment may have to be postponed until mental or behavioral health services are sought.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that M-Care Healthcare may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.

I certify that the above information is true and correct. I have read M-Care Healthcare's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature: ____ Date: ________________________________
Print Name: ______________________________ Legal Name (if different): ________________________________

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Privacy Notice

Name ____ DOB ______________________________

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Passage of the Health Information Portability and Accountability Act (HIPAA) privacy notice occurred to improve the efficiency and effectiveness of the health care system by standardizing the transmission of certain transactions and protecting the privacy and security of the patient's personal health information.

The Privacy Rule essentially controls the use and disclosure of protected health information (PHI). The Security Rule protects and safeguards confidentiality of medical information and information that could identify an individual.

M-Care Healthcare, LLC understands that your medical information is private and confidential. All providers and staff must adhere to these policies.

As required by law, the HIPAA privacy notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. You can request a written copy of our most current privacy notice.

If you have any questions or would like further information about this notice, please ask a member of M-Care Healthcare, LLC staff.

I, ______________________________ (print name), acknowledge that I have read M-Care Healthcare's privacy policies and patient bill of rights and have been offered a copy. I understand that I can request a copy of these documents at any time.

Patient Signature: _____________________________________ Date: ______________________________
Print Name: ___________________________ Legal Name (if different): ______________________________

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Release of Information

Name ____ DOB _______________________________

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to friends/family members, you must sign this form. Only individuals listed on this form will be authorized to obtain/inquire about medical and billing information for the patient.

I authorize M-Care Healthcare, LLC to release and discuss my medical and/or billing information to the following individual(s):

1.____________________________________ Relationship to Patient:____________________

2.____________________________________ Relationship to Patient:____________________

3.____________________________________ Relationship to Patient:____________________

-or-

I do not authorize M-Care Healthcare, LLC to release medical information regarding my treatment at M-Care Healthcare to any individuals. __________(initial here)

Additional Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. __________(initial here)

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. __________(initial here)

I have the right to revoke this consent in writing at any time. __________(initial here)

Patient Signature: ______________________________________ Date: _______________________________
Print Name: ____________________________ Legal Name (if different): _______________________________

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Records Release & Request

Name ____ DOB _______________
Legal Name (if different)___________________________ Preferred Phone Number ________________
Address ____

REQUESTING RECORDS FROM:

Healthcare Provider's Name: ______________________ Practice Name: _________________

Address: ____

Phone Number: _________________________ Fax Number: ______________________________

Check all that apply: ☐ Office Notes ☐ Hospitalizations ☐ Lab Results

☐ Vaccine History ☐ Full Record ☐ Specific Date Range ________-_________

Reason for requesting records: ☐ Continuation of Care ☐ Other _______________________

MAIL OR FAX RECORDS TO:

M-Care Healthcare, LLC

941 W. 27th St. S.

Wichita, Kansas 67217

Phone: (316) 461-0339 Fax: (316) 221-1000

I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address. I further authorize that these medical records may be faxed if necessary. I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

Patient Signature: _____________________________________ Date: _____________________________
Print Name: ____________________________ Legal Name (if different): ______________________________

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No-Show Policy

“No-show” appointments have a significant negative impact on our practice and the healthcare we provide to our patients. As medical professionals committed to providing high quality care, we schedule generous appointment slots to ensure that you can have your concerns addressed at your appointment. Available appointments are in high demand and no-show appointments are unfair to those patients who are waiting to schedule and disrespectful of staff time.

Definition of a “No-Show” Appointment
A “No-show” appointment is any scheduled appointment in which the patient either:
- Does not arrive to the appointment.
- Cancels with less than 24 hours’ notice (consideration will be given for extenuating circumstances).
- Arrives more than 10 minutes late and is consequently unable to be seen.

How to avoid getting a "No-Show"
- Cancel or confirm your appointment prior to 3pm the day prior to your appointment to give our staff time to rebook the slot with another patient.
- Arrive 5-10 minutes early to your appointment to ensure that we are able to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit time.

Consequences of “No-Show” Appointments
- A $25.00 No Show fee will be assessed. This fee is not reimbursable by your insurance company and you will be billed directly for it. The service charge will have to be paid in full in order to schedule your next appointment.
- No medication refills will be given until a follow-up appointment is scheduled and kept.
- If you no-show 3 or more appointments, you may be dismissed from the clinic at the discretion of your medical provider.
- If you are dismissed, further scheduled appointments will be cancelled. Routine medications will be refilled if due within 30 days of dismissal. Controlled substances will NOT be refilled.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances where prior notice could not be given, consideration will be given, and a one-time exception may be granted. You may contact M-Care Healthcare LLC at (316)461-0339. If you do not reach a staff member, please leave a message.

I have read and understood the M-Care Healthcare “No Show” Policy as described above.

Patient Signature: ____ Date: ________________________________
Print Name: _____________________________ Legal Name (if different): ________________________________