HARDER family practice P.A.
2820 Ohio Street Augusta, Kansas 67010-2361 316-775-7500

PATIENT INFORMATION

Legal Name _____DOB ____ - ____ -____Sex M____F____ SS#_____ -_____-_____
Last First M. I.

Address _____Apt _____ City _____ State _____ Zip Code _____-_____

Home Phone (___) _____Cell Phone (____)_____Work Phone (____)_____Ext _____

Preferred Reminder Method (check one) Phone _____ Mail _____ Email _____

Preferred Contact Method (check one) C# _____ H# _____ Wk#_____Email _____

Email Address _____

Employer _____Employer's Address _____

City_____ State _____ Zip Code _____-_____

Marital Status: Single _____ Married _____Divorced _____ Widowed _____ Other_____

Spouse's Name _____ DOB _____ - _____- _____ SS#_____- _____-_____

Spouse's Employer _____ Work Phone (____)_____

Race (check one)
_____ Declined
_____African American
_____ Asian
_____ White
_____ Hispanic
_____ American Indian
_____ Other_____

Ethnicity (check one)
_____Declined
_____Not Hispanic or Latino
_____African American
_____Native American
_____Other_____

Preferred Language (check one)
_____English
_____Spanish
_____German
_____French
_____Other_____

CONSENT TO CONTACT

I give Harder Family Practice, PA., permission to speak to the following person/person's regarding any pertinent medical information.

Name_____ Relationship to patient _____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (_____)_____

Name _____ Relationship to patient _____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (_____)_____

***** PLEASE COMPLETE OTHER SIDE*****

PLEASE COMPLETE INSURANCE INFORMATION

PRIMARY INSURANCE Insurance Company _____

Claims Address _____ City _____ State _____ Zip _____-____

ID/Policy Number _____Group Number _____ Effective Date ___-____-____

Subscriber Name _____ Relation to Pt._____ SS#____-____-_____ DOB ___-___-_____

Address _____ Apt. _____ City _____ State _____ Zip _____-____
(if different from patient)

Home Phone (_____)_____Work Phone (_____) _____ Cell Phone (_____) _____

SECONDARY INSURANCE Insurance Company _____

Claims Address _____ City_____ State _____ Zip _____-____

ID/Policy Number _____ Group Number _____ Effective Date _____ - _____ - _____

Subscriber Name _____Relation to Pt._____ SS# ____-____-_____ DOB ____-____-_____

Address _____ Apt. _____ City _____ State _____Zip _____-_____
(if different from patient)

Home Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____) _____

RESPONSIBLE PARTY INFORMATION

Complete this section if you would like billing information to be sent to someone **OTHER THAN** THE PATIENT.

Name _____ Relationship _____ SS#_____-_____-_____ DOB ____-____-_____

Address _____Apt _____ City _____ State _____ Zip _____-____

Home Phone (_____)_____ Work Phone (_____) _____ Cell Phone (____)_____

I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If item 12 of the CMS-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above in Medicare/ Other Insurance Company assigned cases. Co-pay must be paid at the time of service. Payment is due in full within 60 days of the first statement. Patients who fail to pay the account balance within 60 days will become inactive and unable to schedule appointments or receive refills until paid in full. Patients who fail to pay within 90 days of the first statement will be sent to collections, with an added fee 35%. Please let us know if you need more information.

A Photocopy of these assignments shall be valid as the original.

PATIENT (PRINT NAME) _____

SIGNATURE _____ Todays Date _____

GUARDIAN (PLEASE PRINT) _____ Todays Date _____

REVISED (02/21/2018)