Internal Medicine & Pain Management

ICT INTERNAL MEDICINE AND PAIN MANAGEMENT

7329 W VILLAGE CIR, STE 100
WICHITA, KS 67205
PHONE: 316-260-6363
FAX: 316-260-6301

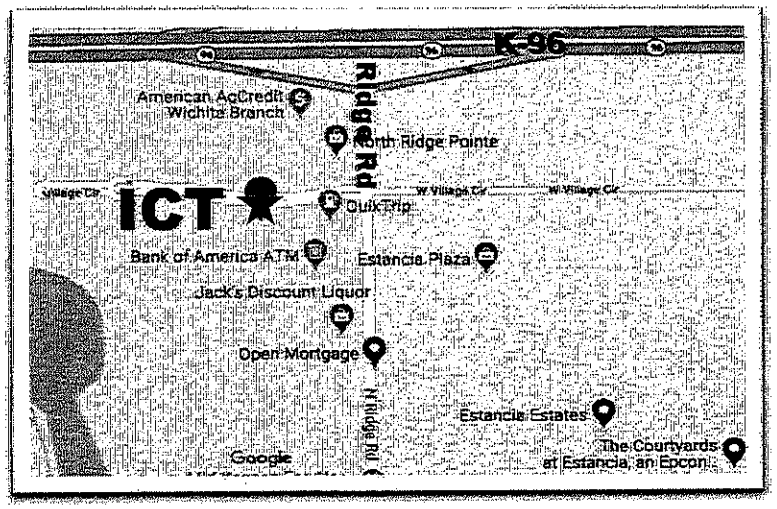
Welcome to ICT Internal Medicine and Pain Management. Included are the forms needing to be completed prior to your appointment on at . Please complete as best as you can. When you come in for your first appointment, make sure to bring any prescriptions with you that you are currently taking. You will also need your current ID and insurance card(s) if you have any. Be prepared with your copay as well.

Please request any pertinent medical records (primary care doctor and/or specialist, and MRI or x-rays) be faxed to 316-260-6301 *prior to your appointment.*

If you have any questions before you arrive, do not hesitate to call. Thank you for your cooperation, and we look forward to assessing and meeting your needs.

Sincerely,

ICT Internal Medicine and Pain Management



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NEW PATIENT INTAKE FORM

patient data

Date:

Title (Check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname: _____ Date of Birth: ____/____/_____ Sex (Check one): ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # - Home: (____) _____ Work: (____) _____ Cell: (____) _____

Email Address: _____

Social Security Number: _____ - _____ - _____ Marital Status (Check one): ☐ Single ☐ Married ☐ Other

Employment Status (Check one): ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Other

employer data

Occupation: _____

Employer Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

spouse data

Is your spouse a patient in the clinic? ☐ Yes ☐ No

First Name: _____ Middle Initial: _____ Last Name: _____

Cell Phone: (____) _____ Email Address: _____

Spouse's Date of Birth ____/____/_____ Spouse's Social Security Number: _____ - _____ - _____

Occupation: _____

insurance

Insured's Full Name: _____ Social Security Number: _____ - _____ - _____

Insurance Company: _____ ID#: _____

Policy Holder's Name: _____ Relationship to Insured: _____

Employer: _____

emergency contact

Emergency Contact Name: _____

Relationship to Patient: _____ Phone Number: (____) _____

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AUTHORIZATION FOR COMMUNICATION

Patient Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

My information may be released to the following individual(s) or organization(s):

Name: _____ Phone Number: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

Name: _____ Phone Number: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

Name: _____ Phone Number: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

Information to be released (Check all that apply):

_____ All Information: Health and Billing

_____ Appointment Dates and Times

_____ Office Visit Notes/Diagnosis

_____ Lab Results/Imaging Reports

_____ Health Information Only

_____ Billing Information

_____ Other

_____ From Dates _____ to _____

If other, please specify: _____

I understand that I have the right to revoke this consent via verbal or written communication at any time.

_____ _____ _____ _____

Signature of Patient/Representative | Print Name | Relationship to Patient | Date

_____ _____

Signature of Witness (ICT Team Member) | Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____ Date of Birth: ____/____/____

By signing this form, I acknowledge that ICT Internal Medicine and Pain Management has provided me with a copy of its Privacy Notice.

_____ _____
Signature of Patient/Guarantor Date

For Office Use Only

ICT Internal medicine and Pain Management staff required to complete if patient had signed or had not signed the Privacy Notice:

1. Was the patient provided a copy of the Privacy Notice?

   ☐ Yes ☐ No

2. Please explain why the patient was unable to sign the Privacy Notice and document what the efforts were in trying to obtain the patient's signature.

   _____
   _____
   _____
   _____
   _____
   _____

   Initials: _____

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PATIENT FINANCIAL POLICY (EFFECTIVE 01-16-2017)

As a patient in our office, patients are required to know that you are responsible for the payment of all medical treatment and related services provided by ICT Internal Medicine and Pain Management.

Patients with insurance coverage:

- It is your responsibility to check with your insurance company prior to your first visit to determine if the physician or provider you are seeing is "in-network" or participating with your specific insurance plan.
- HMO's including but not limited to Premier Blue, PPK, Blue Select, most Medicaid policies and others **REQUIRE** a referral. If your insurance plan requires you to have a referral from your primary physician, you are responsible for obtaining the referral prior to becoming a patient at our office. If you do not have an authorized referral, you will be required to sign a Waiver of Referral which documents that you understand that we will bill you for the services for which there is no referral.
- If your insurance plan requires a co-pay for the office visit, you will be expected to pay the co-pay amount at the time the services are provided. Due to insurance contact and compliance rules, there will be no exceptions. If a co-pay is not collected at the time of service, a $5.00 billing charge will be assessed to cover billing costs. This charge may increase at any time to cover reasonable postal and billing costs.
- If you are covered by health insurance, as a service, and out of consideration to our patients, this office will file insurance claims for all covered services. As appropriate, based on our contractual provision with your insurer, this office will accept your insurance company's maximum allowable reimbursement.
- You will be responsible for any deductible or co-insurance payment amount and for any non-covered services incurred at the time of service. Payment in full is due within 30 days after receipt of payment from your insurance company.
- If you are unable to make payment in full, it is your responsibility to contact our billing office to set up arrangements for payment.

Self-Pay Patients:

- As a self-pay patient, you are required to make a payment prior to seeing a medical provider. Understand that the payment made is a deposit only based upon the anticipated services to be provided. Understand tat any charges not covered by the deposit are your responsibility to pay prior to leaving our office.
- If you are unable to make payment in full, the amount owed to ICT Internal Medicine and Pain Management must be set up on a payment plan. It is your responsibility to contact our billing office to set up arrangements for payment.

All Patients:

- We may collect a non-refundable No-Show charge of $25.00 for any appointment scheduled that is not cancelled or re-scheduled at least 12 hours prior to the time of your appointment. This charge is the responsibility of the patient. It must be paid prior to the patient receiving additional services. If you are more than 15 minutes late, you will be required to reschedule your appointment.

You will receive statements and letters that notify you of the amount you owe and indicate to you the need to communicate with our billing office. If at any time you have questions related to your account, contact our office at 316-260-6363.

Signature of Patient/Guarantor	Date of Birth	Date

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PATIENT RESPONSIBILITY AGREEMENT / REFERRAL WAIVERS

Patient Name: _____ Date of Birth: ____/____/____

I understand that if my insurance requires a referral for the services provided, it is my responsibility for obtaining the referral. If I do not have an authorized referral letter or authorized referral number, and the insurance denies the claim for no referral, I understand that I will be responsible for the bill directly, for the services that are provided to me. The insurance will not be responsible for any charges connected this unauthorized visit.

I have read, understand and agree to the terms above. By signing this form, I acknowledge my responsibility and ICT Internal Medicine and Pain Management's Referral Waiver Policy.

_____
Printed Name of Patient/Guarantor

_____ _____
Signature of Patient/Guarantor Date

_____
Printed Name of Witness

_____ _____
Signature of Witness Date

*This waiver is being used to ensure the integrity and purpose of the primary care physician referral system.

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CONSENT TO TREATMENT AND RIGHT TO REFUSE TREATMENT

Consent:

By signing below, I authorize ICT Internal Medicine and Pain Management and their staff to conduct any diagnostic examinations, tests and procedures to provide any medications, treatments or therapy necessary to effectively assess and maintain my health, and to asses, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment:

In giving my general consent to treatment, I understand that I *retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deem medically necessary by my individual treating healthcare providers.* I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____
Printed Name of Patient/Guarantor

_____ _____
Signature of Patient/Guarantor Date

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ICT MEDICAL ADULT CONFIDENTIAL HEALTH HISTORY FORM (1 of 3)

Patient Name: _____ Date of Birth: ____/____/____

Past Medical History

CARDIOVASCULAR

Atrial Fibrillation	Coronary Artery Disease	Hypertension
Myocardial Infraction	Congested Heart Failure	Hyperlipidemia
Angina	Stroke/CVA	Pacemaker _____
Artificial Heart Valve	SVT	Valve Disease

ENDOCRINOLOGY

Diabetes: Oral / Insulin / Diet	Hypothyroidism	Hyperthyroidism
Osteoporosis	Low testosterone	
Benign Prostatic Hypertrophy		

GASTROINTESTINAL

Crohn's Disease	Gall Bladder disease	GERD
Hepatitis A / B / C	Irritable Bowel Disease	Other Liver Disease
PUD	Gastroparesis	Pancreatitis

HEMATOLOGY/ONCOLOGY

Anemia	DVT/PE	Colon Cancer
Lung Cancer	Prostate Cancer	Breast Cancer
Leukemia	Other Cancers	

MUSCULASKELATAL

Chronic Back Pain	Spinal Stenosis	Osteoarthritis
Rheumatoid Arthritis	Knee Pain	Migraines
Fibromyalgia	Shoulder Pain	Elbow Pain

PULMONARY

COPD	Asthma	Pulmonary Fibrosis
Pulmonary Nodules	Pneumonia	Allergies

PSYCHIATRIC

Anxiety	Depression	Bipolar
Schizophrenia		

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ICT MEDICAL ADULT CONFIDENTIAL HEALTH HISTORY FORM (2 of 3)

OTHERS

HIV
Renal Failure
Alcohol Abuse
STD _____
Seizure

Past Surgical History

Angioplasty with _____ Stent
Back Surgery _____
Colectomy
Hernia Repair
Pacemaker
Appendectomy
CABG _____ Vessels
Colostomy
Hip Replacement
Thyroidectomy
Knee Surgery _____
Cholecystectomy
Gastric Bypass
Knee Replacement
Tonsillectomy

MALE

Prostatectomy
TURP
Vasectomy

FEMALE

Breast Augmentation
C-Section
Tubal Ligation
D/C
Breast Biopsy
Hysterectomy with _____ Ovaries

Family History

DX	Father	Mother	Brother	Sister	Other	Other
Alcoholism						
Allergies						
Alzheimer's						
Blood Disease						
Heart Disease						
Stroke						
Diabetes						
Depression						
Cancer: _____						
Adopted						

Social History

Smoking History:

Cigarettes Cigar Pipe E-Cigs - _____ packs/day None
Quit in _____

Alcohol Use: Occasional Social Daily None

Drug Use: Marijuana Cocaine Methamphetamine IV Drug Use None

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ICT MEDICAL ADULT CONFIDENTIAL HEALTH HISTORY FORM (3 of 3)

MEDICATIONS

MEDICATION NAME	DOSAGE

ALLERGIES

MEDICATION NAME	REACTION

REVIEW OF SYSTEMS

CONSTITUTIONAL Weight Gain Night Sweats Fever Chills Weight Loss Insomnia	**RESPIRATORY** Shortness of Breath Coughing up Blood
ENT Hearing Loss Tinnitus Sore Throat Hoarseness Vertigo Nose Discharge	**GI** Indigestion Ulcer Jaundice Black Stools Constipation Diarrhea Trouble Swallowing
EYE Blurry Vision Loss of Vision	**GU** Difficulty Urinating Blood in Urine
CARDIOVASCULAR Chest Pain Orthopnea Claudication	**MUSCULOSKELETAL** Back Pain Knee Pain Elbow Pain Hip Pain Neck Pain Shoulder Pain
NEUROLOGICAL Numbness _____ Weakness _____ Stroke Headache Seizure	**ENDOCRINE** Feels Hot Feels Cold Hair Loss
PSYCHIATRIC Depression Anxiety Hallucinations	**ALLERGIES** Sneezing Itchy Eyes Skin Rash
HEMATOLOGICAL Bleeding Bruising	

PREVIOUS PHYSICIANS

_____

_____

_____