United Surgical ASSOCIATES of Kansas City

Demographics: Please fill out completely
Each page is FRONT AND BACK

Name First: _____ Last: _____ MI: _____
Date of Birth_____ SSN: _____

Birth Gender: (Please Circle) Male Female
Is your gender identity the same as the sex you were assigned at birth: Yes No

Ethnicity (Please Circle) Caucasian African American Arabic Hispanic Asian Other

Address Information:
Street Address: _____
City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Cell: _____
Is it ok to leave a message on your home phone? Yes No
On your cell phone? Yes No
Consent to text? Yes No
E-Mail Address:_____

Employment Information:
Employer: _____
Occupation: _____ Work #: _____

Preferred Pharmacy: _____ **Location (cross-streets):** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Referring Physician: _____ **Primary Care Physician** _____

Billing Preference: Via Portal:_____ Mail:_____

Insurance Information:

Primary Insurance Company: _____Policy #: _____
Group #: _____ Policy Holder Full Name: _____
Policy Holder DOB: _____ Policy Holder SSN: _____
Relationship to Insured: _____ Insured Employer: _____

Secondary Insurance Company: _____Policy #: _____
Group #: _____ Policy Holder Full Name: _____
Policy Holder DOB: _____ Policy Holder SSN: _____
Relationship to Insured: _____ Insured Employer: _____

Social History:

Marital Status (circle one) Single Married Separated Divorced Widowed
Tobacco (circle one) Current Former Never
If Current or Former: Number of cigarettes per day: _____
Number of years smoked: _____
Alcohol (circle one) Current Former Never
If Current or Former: Number of drinks per day/week: _____ Type: _____
Illicit or Recreational Drugs (circle one) Current Former Never
If Current or Former: Type of drug: _____
Number of years used: _____

Your Medical History: *Circle Yes or No*

Anemia	Yes No	Heart disease	Yes No
Anxiety Disorder	Yes No	Hepatitis	Yes No
Arthritis	Yes No	High Cholesterol	Yes No
Asthma	Yes No	Hypertension	Yes No
Autoimmune Disease	Yes No	Kidney disease	Yes No
Bleeding Disorder	Yes No	Kidney Stones	Yes No
Blood transfusion	Yes No	Liver disease	Yes No
Bronchitis	Yes No	Morbid Obesity	Yes No
COPD	Yes No	Obstructive Sleep Apnea	Yes No
Cancer	Yes No	Psychiatric disorder	Yes No
Coronary Artery Disease	Yes No	Pulmonary Embolism	Yes No
Deep Vein Thrombosis	Yes No	Reflux/GERD	Yes No
Depression	Yes No	Seizures/Epilepsy	Yes No
Diabetes	Yes No	Stomach/intestinal disease	Yes No
Diverticulitis	Yes No	Stroke	Yes No
Eye disease	Yes No	Thyroid disease	Yes No
Gout	Yes No	Tuberculosis	Yes No
Headaches	Yes No		

Other (please explain) Yes No _____

Surgical History

List any surgeries you have had and the approximate date. Example: tonsillectomy, appendectomy, gallbladder removal, tubal ligation, breast surgery/biopsy, laparoscopy.

_____

_____

_____

Family History:	*Circle Yes or No*	*Family relationship to you*
Arthritis	Yes No	_____
Asthma	Yes No	_____
Bleeding Disorders	Yes No	_____
Chronic Lung Disease	Yes No	_____
Depression	Yes No	_____
Diabetes Mellitus	Yes No	_____
GERD	Yes No	_____
Heart Disease	Yes No	_____
High Blood Pressure	Yes No	_____
Mental Illness	Yes No	_____
Obesity	Yes No	_____
Sleep Apnea	Yes No	_____
Stroke	Yes No	_____
Cancer		
Breast	Yes No	_____
Colon	Yes No	_____
Ovarian	Yes No	_____
Other	Yes No	_____
Other	Yes No	_____

Current Medications: (if you have a list please bring to have copy made)

Name	Dosage	How often do you take it?	Date started?

Allergies

Name	Type of reaction

Please complete front and back of each page

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Our commitment here at United Surgical Associates is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Healthcare Information.

During the course of serving your interests it may be necessary to share information with other health care providers or insurance companies. The following are examples of instances where information may be shared.

To acquire or send medical records, workman's compensation claims, and for information to be sent to your referring physician.

United Surgical Associates is committed to obeying all Federal, State and Local laws and regulations regarding privacy practices. If any other purposes or requests arise information will only be released by written authorization of the individual in question or authorized Power of Attorney.

MEDICAL INFORMATION AUTHORIZATION

☐ ***I DO NOT authorize the physician, or anyone associated with his/her group to discuss my medical condition, treatment, or test results with anyone other than myself.**

☐ ***I DO authorize the physician, or anyone associated with his/her medical group to discuss my medical condition, treatment, and test results with the following people:**

_____

Name **Phone** **Relationship**

_____

Name **Phone** **Relationship**

_____

Name **Phone** **Relationship**

_____

Signature of patient or legal representative **Date**

_____

Printed name of patient/legal representative **Relationship**

Please complete front and back of each page

United Surgical ASSOCIATES of Kansas City

APPOINTMENT CANCELLATION/NO SHOW POLICY

Should you need to cancel or reschedule an appointment, please call our office as soon as possible and no later than 24 hours prior to your scheduled appointment.

As permissible by law, our Appointment Cancellation/No Show Policy is below:

- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $25.00 fee. This fee will be due at the time of the patient's next office visit.
- Any patient who fails to show or cancel/reschedule an appointment with no 24 hour notice a second time will be charged a $50.00 fee. The fee for both No Shows will be due before another visit is scheduled.
- These fees are charged to the patient, not the insurance company.

We thank you for trusting your medical care to our practice and being considerate of our time and the time of our other patients.

_____

Signature of patient or legal representative Date

_____

Printed name of patient/legal representative Relationship

United Surgical ASSOCIATES of Kansas City

Kelly M. James, M.D. F.A.C.S.
Sigi P. Joseph, M.D
Chelsea R. Fisher, D.O.
Clinton Gates, M.D.
Shaan Akhtar, M.D.

19101 E Valley View Pkwy, Suite B
Independence, MO 64055

General Surgery

Hello,

It is our mission here at United Surgical Associates to make your experience with our practice as pleasant and transparent as possible. Part of this service is to contact your insurance company(s) to determine your out-of-pocket expenses prior to your visit or procedure so that you may include this information in your decision-making process. It is important for you to remember that this will be an estimate, and while we will do our best to give you the most accurate number, there are many variables which could change this number prior to your visit or procedure.

Once your benefits have been verified, our insurance team will contact you to discuss our physician's fee for your surgical procedure. The fee includes the proposed surgery and routine, uncomplicated post-operative care in the hospital and in our office. The fee does not include the anesthesiologist's fee, the hospital costs or any laboratory costs. It is an estimate only and does not include any additional procedures that may be performed, if necessary, at the time of the surgery.

We ask that you make a payment, for the estimated patient responsibility due, prior to your surgical procedure and payment of any patient remainder within 45 days of the surgery. For procedures that are not covered by insurance, or for patients who do not have medical insurance, we require full payment (100%) prior to your surgical procedure.

We accept cash, checks, debit and all major credit cards. Payments can be made through our office or online at **www.usa-kc.com**. In order to provide further assistance to our patients, our office has partnered with Green Sky financing to provide several financing options for qualifying patients. Additional information can be found at **www.GreenSky.com**.

Thank you for choosing us to be part of your health care team!

_____ _____

(Patient signature) (Date)

Please complete front and back of each page