

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1, Baxter, MN 56425
(This information is necessary for our files & will be considered confidential)

PATIENT'S FULL NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ SEX: M F

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL _____

PRIMARY PHONE # TO CONTACT YOU: _____

ALTERNATE PHONE #: _____

ALTERNATE PHONE #: _____

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ CONTACT INFO: _____

WOULD YOU LIKE TO HEAR ABOUT UPCOMING SEMINARS, PROMOTIONS, AND SPECIALS

____yes ____no

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER (IF OTHER THAN PATIENT):

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER (IF OTHER THAN PATIENT):

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled; to be made on my behalf to Kurtis Waters MD, PA for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance.

This facility does not deny any benefits or service because of race, color, national origin, age gender, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

Signature _____

Date _____

(Legal Guardian if minor)

Name: _____

Date of Birth: _____

Past Medical History

Have you been treated for:

	No	Yes		No	Yes
				<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Allergy	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
			Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Alcohol Problem	<input type="checkbox"/>	<input type="checkbox"/>
			AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
			Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
			Anesthesia Problem	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>

List Surgeries/Pertinent Hospitalizations: _____

Family Medical History

	No	Yes	Relative		No	Yes	Relative
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>		Anesthesia Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>					

Social

Tobacco:

Smoking Y N Quit _____

Chew Y N Quit _____

Education: _____

Occupation: _____

Alcohol – Drinks/week _____

Exercise Program Y N

Daily Aspirin use Y N

**AUTHORIZATION FOR RELEASE OF INFORMATION
AND FINANCIAL RESPONSIBILITY**

RECORD RELEASE: I authorize Kurtis Waters MD, PA to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other providers involved in my care.

_____ **Initial**

PHOTOGRAPHS: I hereby give permission to my provider or any assistant designated, to take photographs to enhance the medical record and for diagnostic purposes. I understand that they may show them to other health professionals to help with my skin care and for educational purposes for their patients.

_____ **Initial**

ASSIGNMENT OF BENEFITS: I authorize payment of Medical/Medicare benefits to Kurtis Waters MD, PA for any services furnished by this clinic to me. I understand that I am financially responsible for charges not covered by Medicare and/or my insurance carriers. This authorization also covers charges generated by Kurtis Waters MD, PA for services received at St. Joseph's Medical Center or other medical facilities.

_____ **Initial**

PRIVACY PRACTICE: I hereby acknowledge that I have received a copy of Kurtis Waters MD, PA Notice of Privacy Practices.

_____ **Initial**

FINANCIAL POLICY: I hereby acknowledge that I have received a copy of Kurtis Waters MD, PA Financial Policy.

_____ **Initial**

I permit a copy of this authorization to be used in place of the original.

SIGNATURE _____ DATE _____

(Relationship if patient is a minor: _____)

Financial Policy

This is an agreement between Kurtis Waters, MD, PA, as creditor, and the patient/debtor named on this form. In this agreement, the words “you,” “your,” and “yours” mean the patient/debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Kurtis Waters, MD, PA.

By executing this agreement, you are agreeing to pay for all services that are received.

Benefits:

- It is patient responsibility to verify any and all coverage, eligibility, and benefit levels per their individual insurance policy(s). We are unable to quote any benefits and/or allowed amounts for your visit. Please contact your insurance company directly with any policy concerns.

Policy for patients with contracted insurance companies:

- If we are contracted with your insurance company, we must follow our contract and their requirements.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy.
- It is the insurance company that makes the final determination of your eligibility.
- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.
- You agree to pay any portion not covered by your insurance.
- We are currently contracted with the following insurance companies: BCBS MN and its affiliates, Cigna, Medica (including Select Care, Labor Care, and United Healthcare), Medicare and Medicare Replacement plans, Minnesota Medical Assistance, Preferred One, Ucare, and Health Partners.

Policy for patients with non-contracted insurance companies:

- Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will submit your charges to your insurance as a courtesy to you.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy.
- It is the insurance company that makes the final determination of your eligibility.
- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.
- You agree to pay any portion not covered by your insurance.

Policy for Cosmetic Procedures:

- Payment in full is required on the date of service for all injections and cosmetic consultations. No same day discount applies as cosmetic procedures are already set at a discounted rate.
- Payment for a scheduled cosmetic surgery must be received 14 days prior to the date of surgery. If this payment is received after that date, surgery may be rescheduled from 14 days of receipt of payment.
- Payment types accepted are: cash, check, Visa, MasterCard, Discover, or Care Credit.

Statements:

- You will receive a statement on any remaining balance directly after we receive notification from your insurance company.
- BALANCE IN FULL is due upon receipt of statement.
- Payment options include: cash, check, Visa, MasterCard, Discover, or Care Credit.

Returned Checks:

- Any checks returned by your financial institution will be assessed a fee of \$25.00.

Past due accounts:

- If your account becomes past due, we will take any and all necessary steps to collect this debt. If we refer your account to an outside collection agency, all future correspondence regarding that debt will need to be made directly through the collection agency.
- We reserve the right to cancel your privileges to make charges against your account at any time due to delinquent balances.
- If a balance remains unpaid, any future care you may need by our office could be affected.

Waiver of confidentiality:

- You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date:

- Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party: _____
(If not the patient)

Signature: _____ Date: _____

Kurtis Waters, MD PA

Policy for non-insured medically necessary procedures:

- Payment in full is due on the date that services are rendered.
- Patient will receive a 30% discount of normal fee rates for same day payment.
- Payment types accepted are: cash, check, Visa, MasterCard, Discover, or Care Credit.

Patient's Name: _____

Responsible Party: _____
(If not the patient)

Signature: _____ Date: _____

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1, Baxter, MN 56425

**THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS
INFORMATION. PLEASE REVIEW IT CAREFULLY.**

1. Kurtis Waters MD, PA is permitted to make uses and disclosures of **protected health information** (PHI) for treatment, payment, and health care operations, as described in the following examples:
 - a. For treatment – (e.g., to discuss your PHI with other healthcare providers)
 - b. For payment – (e.g., to submit information to your insurance company)
 - c. For health care operations – (e.g., to send the minimum necessary of your PHI to other healthcare providers as appropriate)
2. Kurtis Waters MD, PA is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Minnesota state law, when more stringent than federal law, will be followed.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Kurtis Waters MD, PA may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
5. The individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. Kurtis Waters MD, PA is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Kurtis Waters MD, PA is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
7. Kurtis Waters MD, PA is required to abide by the terms of the Notice currently in effect.
8. Kurtis Waters MD, PA reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Kurtis Waters MD, PA will provide individuals or patients with a revised Notice on request in person or by mail after an official public notification in the Brainerd Daily Dispatch.
10. Individuals may complain to Kurtis Waters MD, PA and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated by calling or writing and requesting a complaint form.
11. Kurtis Waters MD, PA contact person for matters relating to complaints is:

Call:

Privacy Officer @ 218-454-8888

Or **Write** to:

Kurtis Waters MD, PA
13359 Isle Drive, Suite 1
Baxter, MN 56425

12. This Notice is first in effect 12/1/2007.