



1106 E 27th Suite #2

Phone: 785-625-5500

Fax: 785-625-5501

Patient Information	Insurance Information
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Full Name _____

Primary Medical Insurance

Birthdate _____ SS# _____

MEDICARE BCBS WORK COMP NONE

Race _____ Ethnicity _____
 (EX: White, Asian, Declined) (EX: Hispanic, Not Hispanic, Declined)

OTHER _____

Age _____ MALE FEMALE

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD TO BE PHOTOCOPIED.

Address _____

Additional Insurance

CITY _____ STATE _____ ZIP _____

Is patient covered by additional insurance ___Yes ___No

Home Phone _____

Insurance Company _____

Cell Phone _____

Employment Information	Emergency Contact
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Employer _____

Contact Name _____

Work Phone _____

Relationship _____

Employer Address _____
 CITY STATE

Daytime Phone _____

Spouse Information	Medicare Screening Information
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Full Name _____

Is patient a veteran? YES NO

Birthdate _____ SS# _____

If yes:

Employer _____

a. Did the VA refer the patient? YES NO

Work Phone _____

b. Does the patient have "fee basis ID card?"
 YES NO

Employer Address _____

Does the patient have a Federal Black Lung Card?
 YES NO

CITY STATE

Is this visit due to an accident?
 YES NO

How did you hear about us? Web site, Phonebook, Newspaper, Word of Mouth, Other (please list) _____
 (Please Circle)



1106 E 27th Suite #2
Hays, KS 67601

Phone: 785-625-5500
Fax: 785-625-5501
Email: tknoll@knollclinic.com

NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____
 DAY PHONE _____ HOME PHONE _____ PHARMACY _____
 CELL PHONE _____ EMAIL _____

Reason For Your Visit _____

CURRENT PROBLEMS:

Which of the following additional symptoms are you currently having?

Back Pain		Fatigue		Night Sweats	
Bladder Leakage		Feelings of Depression		Painful Periods	
Blood in your urine		Fever		Persistent cough	
Bloody or black stools		Frequent nausea/vomiting		Sexual difficulty	
Breast discharge		Frequent indigestion		Shortness of breath	
Breast lumps		Frequent urination		Skin disorder	
Chest pains		Hard to empty bladder		Sleeping problems	
Chronic constipation		Headache		Sores on penis/vagina	
Chronic diarrhea		Heart palpitations		Temporary loss of speech	
Cold intolerance		Heat intolerance		Temporary loss of strength	
Coughing up blood		Joint pains		Vaginal discharge	
Difficulty hearing		Menstrual problems		Vision changes	
Easy bruising/bleeding		Mole changes		Weight gain	
Excessive sweating		Nasal congestion		Wheezing	
Fainting/blackout		Nervousness/anxiety		Other:	

PAST MEDICAL HISTORY:

Please review the list below and check any problems you are currently having or have had in the past.

Abnormal PAP smear		Colon polyps		Heart disease		Prostate problems	
Acne		Congestive heart failure		Hepatitis		Psoriasis	
Alcohol Abuse		Depression		High blood pressure		Reflux/heartburn	
Anemia		Diabetes		High cholesterol		Rheumatoid arthritis	
Anorexia		Diverticulosis/diverticulitis		Irritable bowel syndrome		Rosacea	
Anxiety disorder		Drug abuse		Kidney stones		Seasonal allergies	
Asthma		Emphysema		Kidney infections/disease		Seizures	
Atrial Fibrillation		Eczema		Lupus		Sexually transmitted disease	
Blood clot		Frequent bladder infections		Melanoma or other skin cancer		Stroke	
Blood transfusion		Frequent sinus infections		Migraines		Tuberculosis	
Breast cancer		Gout		Osteoarthritis		Thyroid disease/cancer	
Chronic bronchitis/cough		Glaucoma		Osteoporosis		Stomach ulcers	
Crohn's disease		Heart attack		Positive TB skin test		Ulcerative colitis	

Other medical problems not on list: _____

Have you had SURGERY in the past? ()Yes ()No If yes, please check or list:

TYPE OF SURGERY	YEAR	TYPE OF SURGERY	YEAR
Appendectomy		Hysterectomy	
Arthroscopy (joint)		Knee Replacement	
Back Surgery		LEEP/LOOP (Cervix)	
Bypass Surgery/(Heart)		Mastectomy/Lumpectomy	
Cataract Surgery		Neck Surgery	
Cesarean Section		Polyp Removal	
Gallbladder Removal		Tonsillectomy	
Hemorrhoids		Vasectomy/Tubal Ligation	
Hernia		Plastic Surgery	
Hip Replacement		Other:	

Have you ever been Hospitalized? ()Yes ()No For what? _____

CURRENT MEDICATIONS: (please include over the counter medications and food supplements)

Drug Name	Dose	How Often	Drug Name	Dose	How Often

Are you allergic to any medications? ()Yes ()No

Drug Name	Type of Reaction

FAMILY HISTORY: (parents, siblings, grandparents, aunts, uncles, children)

Have any of your family members had any of the following problems?

Condition	Family Member & Age of Onset	Condition	Family Member & Age of Onset
Heart Disease/Attack		Osteoporosis	
Stroke		Migraines	
Diabetes		Breast Cancer	
High Blood Pressure		Colon Cancer	
High Cholesterol		Prostate Cancer	
Thyroid Disease		Lung Cancer	
Depression		Ovarian Cancer	
Other Mental Illness		Uterine Cancer	
Alcoholism		Skin Cancer	
Asthma		Other Cancer	

Any other illness in the family not listed: _____

Has anyone in your immediate family died before the age of 50? ()Yes ()No

If yes, please explain: _____

Social History:

Occupation: _____

Marital Status (circle one) **Single** **Divorced** **Separated** **Married** **Widowed**

Do You Have Any Children? ()Yes ()No Please list names and ages: _____

Who Lives With You? _____

Health Habits:

1. Do You Exercise? ()Yes ()No If so, what type and how often? _____
2. Do you currently smoke? ()Yes ()No If so, how much? _____ How Long? _____
3. Did you smoke in the past? ()Yes ()No How many years? _____ How Much? _____ Quit Date _____
4. Are you exposed to smoke? ()Yes ()No
5. Any other tobacco use? ()Yes ()No Type: Cigar Chewing tobacco Snuff other _____
6. Do you drink caffeine? ()Yes ()No If so, how much? _____
7. Have you ever used street drugs? ()Yes ()No Which Ones? IV drugs Cocaine Heroin Marijuana Downers Inhalants
- Other: _____
- Are you still using drugs? ()Yes ()No Which one(s)? _____
8. Do you drink alcohol? ()Yes ()No What kind? Beer Wine Liquor
- Other: _____
- If so, how often? _____
- How many at one time? _____
- Have you ever had a problem with alcohol in the past? _____
9. Are you sexually active (in the last year)? ()Yes ()No If yes, please circle all that apply: 1 partner multiple partners male partner(s) female partner(s)
10. Are you currently using birth control? ()Yes ()No Which one? Condoms The Pill
- Other _____
11. Do you wear sunscreen? ()Yes ()No
12. Have you had your yearly eye exam? ()Yes ()No
13. Have you had your dental exam this year ()Yes ()No
14. Do you wear your seatbelt every time you drive? ()Yes ()No
15. Do you have a living will? ()Yes ()No
16. Is there any concern for your safety? (emotional, physical, or sexual abuse) ()Yes ()No

Health Maintenance:

Have you ever had the following?

- Cholesterol Screening ()Yes ()No
Results: _____
- Sexually Transmitted Disease Screening ()Yes ()No
Results: _____
- Tetanus Shot ()Yes ()No
What Year? _____
- Colon Cancer Screening ()Yes ()No
Colonoscopy (what year) _____
Flex sig. (what year) _____
- Flu Shot? ()Yes ()No When? _____
- Pneumonia Vaccine? ()Yes ()No When? _____

For Women:

- What was the date of your last menstrual period? ____/____/____
- How many pregnancies have you had? _____ births? _____ miscarriages? _____ abortions? _____
- PAP smear? ()Yes ()No Date ____/____/____ Results _____
- Mammogram? ()Yes ()No Date ____/____/____ Results _____
- Bone Density? ()Yes ()No Date ____/____/____ Results _____

KNOLL CLINIC LLC

NOTICE OF PRIVACY PRACTICES

Effective 9/1/2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The privacy of your health information is very important to us. We are required by law to:

- Maintain the privacy of your health information
- Give you this Notice of our legal duties and privacy practices
- Follow the terms of this notice

This notice will remain in effect until we revise it. We reserve the right to change our privacy practices and the terms of this notice. Any changes we make will apply to all of the health information about you we maintain. We will make you aware of any changes by:

- Posting the revised notice in our office and/or;
- Making copies of the revised notice available upon your request (either at our office or through the contact person listed in this notice)

WHAT IS HEALTH INFORMATION?

Your health information is information that identifies you and relates to:

- Your past, present, or future physical or mental health or condition
- The treatment we provide to you
- Payment for your past, present or future health care

Your health information includes your name, address, Social Security number and other demographic information. Typically, we keep your health information in our medical and billing records.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Written authorization to release health information is required in the following instances:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of protected health information for marketing purposes
- Disclosures that constitute a sale of protected health information
- Other uses and disclosures not described in this notice

How may we disclose your information?

We use your health information to make sure we can appropriately treat you, receive payment for our services and conduct our necessary health care operations. Some examples are:

Treatment: The doctors, nurses, and other staff of Knoll Clinic will use your health information to determine the medical care, tests, procedures and medications you may need. We may disclose your health information to coordinate or manage your health care. For example, we may disclose your information to another health care provider to order a referral, prescriptions, lab work or an x-ray for you.

Appointment: Reminders and Other Contacts: We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.

Payment: We will use your health information to check your eligibility for insurance coverage and prepare a bill to send to you or your insurance company. We will disclose your health information to others to bill and collect payment for our services. For example, in order to bill an insurance company, we will have to disclose information about when you were treated, the conditions you were treated for, and the type of treatment you received.

Health Care Operations: We may use and disclose your health information to allow us to perform functions necessary for our business of health care. For example, within our organization, we may use your information to help us train new staff and conduct quality improvement activities. We may disclose your information to consultants and other business associates who help us with billing, computer and transcription services. In limited situations, we may disclose information to allow other health care organizations to perform their health care operations. For example, we may disclose your information to your insurance company to allow them to conduct quality improvement activities.

Required by Law: We will disclose your health care information when required to do so by law.

Worker's Compensation: We will disclose your health information to comply with worker's compensation and similar laws that provide benefits for work-related injuries and illnesses.

Public Policy: There are several situations in which the law permits or requires us to use or disclose your health information for public policy purposes. These are:

-Public Health Concerns: We may disclose your health information to public health authorities for certain public health activities such as reporting births or deaths, preventing or controlling disease, and notifying persons who may have been exposed to a disease or may be at risk for spreading a disease.

-Health Oversight Activities: We may disclose your health information to a health oversight agency to conduct audits, investigations, inspections and other activities necessary for the government to appropriately monitor the health care system.

Special Situations: There are some situations that occur rarely, but may require or permit us to use or disclose your health information. These may include:

-Abuse, Neglect or Domestic Violence: We may disclose your health information to the appropriate authorities if necessary to report suspected abuse, neglect or domestic violence.

-Serious Threats to Health or Safety: We may use or disclose your health information when necessary to avert a serious threat to the health or safety of you, another person or the public.

-Organ Donation: We may disclose your health information to an appropriate organization to facilitate organ or tissue donation or transplantation.

-Problems With Products: We may use or disclose your health information to report problems with medical devices or other products that are regulated by the Food and Drug Administration or to allow for product recalls, repairs or replacements.

-Legal Proceedings: If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting your information.

-Law Enforcement: We may disclose your health information for law enforcement purposes, as long as we follow specific requirements and restrictions. For example, we may disclose your information to comply with laws that require the reporting of certain types of injuries, to help identify or locate a criminal suspect, or to provide information about the victim of a crime.

-Coroners, Medical Examiners, and Funeral Directors: We may disclose your health information to a coroner, medical examiner or funeral director to allow them to perform their duties.

-Specialized Government Functions: We may disclose your health information as it relates to some specialized government functions, such as military or veterans activities or national security.

-Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your health information to the institution or official as necessary to provide you with health care, protect the health and safety of you or others, and maintain the safety and security of the institution.

When may we make other disclosures of your health information?

For some purposes, we will give you the opportunity to agree or object to a disclosure of your health information. These purposes are:

-Persons Involved In Your Care: If you are present, we may disclose your health information to a relative or other person involved in your treatment or payment for your treatment, but only if you have had an opportunity to agree or object to that disclosure. For example, you may indicate that you don't mind us disclosing your information to a friend or family member by allowing them to join in your meeting with your doctor. If you are not present to agree or object, we will use our professional judgment to determine if disclosing your health information is in your best interests.

-Notifications: We may disclose your location or general condition to notify a family member, personal representative or other person responsible for your care.

If you authorize us to disclose your health information, you may revoke that authorization in writing at any time. If you revoke your authorization we will no longer use or disclose your information for the purposes covered by your authorization. You must understand, however, that we are unable to take back any disclosures we have already made in reliance on your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your health information. We ask that you submit your request to do so in writing. We may charge you a reasonable fee. In some limited circumstances, we may deny you your request to inspect and copy your information. If that happens, you may ask that the denial be reconsidered. Your request and the denial will then be reviewed by a different licensed health care professional --not the one who originally denied your request. We will comply with the decision that professional makes.

Right to Request Amendment: If you believe that health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You must explain the reasons for your request. We may deny your request if the information you are asking us to change:

- Was not created by us (unless the person that created the information is no longer available to make the amendment)
- Is not part of the health information kept by or for us
- Is not part of the information you are permitted to inspect and copy; or
- Is already accurate and complete

If we deny your request, you have the right to file a statement of disagreement with us. Your statement will be included in any disclosures of your information we make in the future.

Right to Restrict Certain Disclosures to a Health Plan: You have a right to restrict certain protected health information to a health plan where you pay out of pocket in full for the healthcare item or service.

Right to Request Restrictions On Uses and Disclosures of Your Health Information: You have the right to ask us to limit how we use and disclose your health information for your treatment or our payment and business operations purposes. You may also ask that we not disclose your health information to family members or friends involved in your treatment or payment for your treatment.

Right to be Notified of Breach: You have the right to receive a written or verbal notice following a breach of unsecured protected health information

Right to Request Confidential Communication: You have the right to ask us to communicate with you about health matters in a specific way or at a specific location. For example, you may ask that we only contact you at work or by mail. We ask that you make your request for confidential communication in writing. We will comply with reasonable requests.

Right to Opt Out of Fundraising Communications: You have the right to opt out of fundraising communications by submitting a request in writing

Right to Receive an Accounting of Certain Disclosures of Your Health Information We Have Made: You have the right to ask us to give you an accounting of certain disclosures of your health information we may have made. This accounting will not include all disclosures. For example, it will not include disclosures made:

- For your treatment or for payment of your treatment
- For our business operations purposes
- To, or authorized by, you
- To others involved in your care or payment for your care

We ask that you submit a request for an accounting in writing. You may ask for up to six-years of disclosures, but the accounting will not include disclosures made before June 1, 2009. One accounting within any 12 month period will be free of charge. We may charge a reasonable fee for additional accountings, but we notify you of the fee and allow you to withdraw or modify your request before we process it.

You have a right to receive a paper copy of this notice even if you have agreed to receive it electronically.

To exercise any of these rights, please contact Grady Knoll at the following:

Knoll Clinic	Phone: 785-625-5500
1106 E 27th Suite #2	Fax: 785-625-5501
Hays, Ks 67601	

IF YOU HAVE COMPLAINTS OR QUESTIONS

You may send a written request directly to the department of health and human services at:

Office of Civil Rights
Hubert H. Humphrey Bldg.
Room 509F
200 Independence Ave. Southwest
Washington, D.C. 20201