[COMP_SITE_NAME]
Patient Registration Information

PATIENT INFORMATION

First | MI | Last | Date of Birth | Age | Sex M ( ) F( )

Street Address | Apt | City | State | Zip | Primary #: ( ) - | Secondary #: ( ) -

SSN | Marital Status Single ( ) Married ( ) Divorced ( ) Widowed ( )

Email: | DL State | DL #

CURRENT EMPLOYER

Employer | Phone: ( ) - Ext

Street Address | City | State | Zip

GUARANTOR INFORMATION

First | MI | Last | Date of Birth | Sex M ( ) F( )

Street Address | Apt | City | State | Zip | Primary #: ( ) - | Secondary #: ( ) -

SSN | Employer

EMERGENCY CONTACT

First | MI | Last | Relationship to Patient | Sex M ( ) F( )

Street Address | Apt | City | State | Zip | Primary #: ( ) - | Secondary #: ( ) -

INSURANCE INFORMATION

Primary Insurance Name | ID/Certificate Number | Group ID/Number

Policy Holder (Subscriber) Name | Subscriber Birth Date | Subscriber Sex M ( ) F( )

Secondary Insurance Name | ID/Certificate Number | Group ID/Number

Policy Holder (Subscriber) Name | Subscriber Birth Date | Subscriber Sex M ( ) F( )

DEMOGRAPHICS

Please Circle Your Race:

Black/African American | American Indian | Asian | Hawaiian/Pacific Islander | White | Other

Please Circle Your Ethnicity:

Hispanic/Latino | Not Hispanic/Latino | Other

Preferred Language:

PREFERRED PHARMACY

Primary Pharmacy Name | Address | Phone Number ( ) -

Secondary Pharmacy Name | Address | Phone Number ( ) -

I hereby give lifetime authorization for payment of insurance benefits to be made directly to [COMP_SITE_NAME], and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original.

Date: _____ Signature: _____

Concierge Medicine of Wichita, LLC
Dr. Aly Gadalla

Authorization for Medical Release of Medical Records

Name:
DOB:
Address:

Information to be released:
- ☐ Office Notes
- ☐ Medication List
- ☐ Lab & X-Ray Reports
- ☐ Other: _____

I hereby authorize _____ to release the above information to:

Concierge Medicine of Wichita
Dr. Aly Gadalla
9449 E 21st Street North, Ste 200
Wichita, KS 67206
T:(316) 462-1070 F:(316) 462-1078

OR

I hereby authorize Concierge Medicine Of Wichita, Dr. Aly Gadalla, to release the above information to: _____

I understand that this information is not to be released to any person or facility except as provided by law. This release will continue until termination of treatment unless otherwise specified. I understand I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

_____ _____
Signature of Patient/Legal Guardian Signature of Witness

_____ _____ _____ _____
Printed Name of Patient Date Printed Name of Witness Date

IMMUNIZATION FORM

HISTORY - INCLUDING MAJOR MEDICAL, DEVELOPMENTAL OR ALLERGIC PROBLEMS

Patient Name: **Date of Birth:**

Chickenpox? Yes / No / Immunized Date of Infection: _____

LABORATORY TESTS

	Date	Results
Urinalysis	_____	_____
Lead Test	_____	_____
Hematocrit	_____	_____
Cholestrol	_____	_____

PHYSICAL EXAMINIATIONS - MOST RECENT AND CURRENT MEDICATIONS

Physical Date: _____ Height: _____ Weight: _____ BP: _____

Examination was normal unless abnormalities are listed below:

This patient is fit for competitive sports and physical education unless noted otherwise below:

Doctors Signature:_____

[SITE_NAME]
[SITE_ADDRESS1] [SITE_ADDRESS2]
[SITE_CITY_STATE_ZIP]
[SITE_PHONE]

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization: I, , authorize **Concierge Medicine of Wichita, LLC** to use and disclose the protected health information described below to:

NAME	RELATIONSHIP	HEALTH INFORMATION		FINANCIAL INFORMATION	
		YES	NO	YES	NO
1.					
2.					
3.					
4.					
5.					

2. Effective Period: This authorization for release of information covers all past, present, and future periods of healthcare unless specifically stated: from _____ to _____.

3. Extent of HEALTH INFORMATION Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I acknowledge that I have received a copy of the Concierge Medicine of Wichita **HIPAA Notice of Privacy Practices.**

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient

Concierge Medicine of Wichita, LLC
Dr. Aly Gadalla
Patient-Physician Opioid Therapy Agreement

Date:
Patient:
DOB:

Initial each statement, list your pharmacy and sign at the bottom.

____ I understand that a reduction in the intensity of my pain is the goal of this program.

____ I realize that all the medications have potential side effects. I will have the recommended laboratory studies required to help make the regimen as safe as possible.

____ I will not use anycontrolled substance without the permission of Dr. Gadalla.

____ I will not use any illegal or illicit substances, including marijuana, cocaine, etc.

____ I will not share, sell or trade my medication for goods or services.

____ I will not attemp to get pain medication from any other doctor without telling them that I am a patient of Dr. Gadalla. If my primary physician or another physician is willing to prescribe my medication, Dr. Gadalla will have to approve the arrangements to make sure there is no duplication.

____ I will not use fraudulent reporting to try to obtain more medication.

____ If my medication is stolen, I will have to produce a police report to substantiate my claim. I understand that my medication may not be replaced and that it is up to the discretion of Dr. Gadalla. If a police report is not produced, I may be discharged from Dr. Gadalla's care.

____ I understand that I am responsible for my medicine; if it is lost it will not be replaced. Medications will be given to help reduce any symptoms of withdrawal.

____ I am willing to undergo periodic random testing of my urine or blood for the purpose of determining my adherence with the regimen.

____ I understand that when medications are prescribed, a thirty (30) day supply is ordered. I will not attempt to get my medication early, nor will I call on nights or weekends to try to get medications.

____ I will take my medications as prescribed and obtain Dr. Gadalla's office approval prior to any changes in the way I take my pain medications. I will make no changes in my therapy without approval from Dr. Gadalla's office.

____ Failure to adhere to the above conditions will result in discontinuation of pain management with Dr. Gadalla. I will be referred to my primary care physician or other pain management physician or facility.

You should only use one pharmacy to fill your prescriptions for pain medication. This helps to ensure the pharmacy has your medication in stock for refills and they understand you have a legitimate need for the medication. Please list your pharmacy below. Should you need to change pharmacies, you must notify our office.

Pharmacy Name: _____

City/State: _____

Phone: _____

CLINIC REFILL GUIDELINES

Requests for medication refills will be taken between 9 AM and 4:00PM Monday through Thursday.
No refills will be handled FRIDAY.

Medication refills will not be given or called in on holidays, weekend, or nights.

Call 316-462-1070 for all refill requests and any other questions regarding your pain and symptom management.

- Call at least 3 office days before your last dose of medication and at least 7 days before your medication needs to be mailed. This will ensure that you will not unnecessarily be without medication
- Renewals are contingent on keeping all scheduled appointments and early refills will not be given.
- Some prescriptions cannot be refilled by phone and require an office visit.

Keep all medications in a secure place. Do not sell, trade or give away your medications. If your medication is damaged, stolen or lost, please discuss the problem with your doctor at once.

At each office visit, you and your doctor should decide on the regimen to be followed to relieve your pain. **Changes in therapy should not be made without first discussing with your physician or other palliative care member.**

If you become pregnant, notify our office as soon as possible.

If all the above guidelines are not adhered to , a more stringent written agreement between you and your physician may be necessary to continue receiving pain and symptom control through the palliative care service.

By signing this informed consent, you give your physician the right to discuss all treatment details with dispensing pharmacists and/or other professionals who provide your health care for the purposes of maintaining accountability and optimizing your pain and symptom control. This is an unrestricted permission.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Concierge Medicine of Wichita
9449 E 21st Street North
Suite 200
Wichita, KS 67206

Patient Name: **[PAT_NAME_FMILS]**
DOB: **[PAT_DOB_FS]**

Concierge Medicine of Wichita, LLC
Dr. Aly Gadalla
Patient Questionnaire

Date:
Name:
DOB:

Why are you here today? _____

Have you had any of these?

Weight Gain	No	Yes		Constipation	No	Yes	
Weight Loss	No	Yes		Diarrhea	No	Yes	
Low Energy	No	Yes		Urinary Trouble	No	Yes	
Skin Changes	No	Yes		Frequent Urination	No	Yes	
Hair Loss	No	Yes		History of Fractures	No	Yes	
Seizures	No	Yes		Kidney Stones	No	Yes	
Vision Changes	No	Yes		Excessive Sweating	No	Yes	
Chest Pains	No	Yes		Fainting Spells	No	Yes	
Headaches	No	Yes		Joint Pain	No	Yes	
Major Head Trauma	No	Yes		Hot Flashes	No	Yes	
Trouble with Decisions	No	Yes		Night Sweats	No	Yes	
Hoarseness	No	Yes		Trouble Swallowing	No	Yes	
Memory Loss	No	Yes		Difficulty Relaxing	No	Yes	
Thyroid Trouble	No	Yes		Breathing Problems	No	Yes	
Low Sex Drive	No	Yes		Muscle Weakness	No	Yes	
Skipped Heartbeat	No	Yes		Swelling in Feet	No	Yes	
Shaking/Trembling	No	Yes		Shortness of Breath	No	Yes	
Sleep Trouble	No	Yes		Abdomen Pain	No	Yes	
Loss of Sensation	No	Yes		Muscle Cramps	No	Yes	
Blood in Stools	No	Yes					

Any Allergies to Food, Drugs, Other?

_____

_____

Medications (name, strength, dose, frequency)**:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Immunization and Date:

Flu	No	Yes,	Date: _____
Pneumonia	No	Yes,	Date: _____
Shingles	No	Yes,	Date: _____

List Your Medical Problems Conditions:

_____

_____

Family Health History:

Grandparents: _____

Father: _____

Mother: _____

Brothers/Sisters: _____

Son/Daughter: _____

Marital Status: Single Married Separated Divorced Widowed

Have you been sexually active in the last month? No Yes

Have you **EVER** used any of the following? Marijuana Cocaine Heroine IV Drugs

Do you drink Alcoholic Beverages? No Yes, _____(number) of drinks per week

Do you smoke? No Yes

If you have quit smoking, when did you quit? _____

What do you do for exercise? _____ How often? _____

When did you last see a dentist? _____ Eye doctor? _____

Patient Financial Policy

Thank you for choosing Concierge Medicine of Wichita as your health care provider. We are committed to your treatment being successful. Your clear understanding of our Patient Financial Responsibility is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your responsibilities. Carefully review the following information and return the last page of this form with your signature and date.

We request all patients complete our patient packet prior to seeing the physician and annually thereafter. It is your responsibility to notify our office of any patient information changes (address, name, insurance information, Etc.)

FMLA PAPERWORK- There is a $15.00 charge for completion of FMLA paperwork. Payment is requested at the time of the request. We ask that FMLA paperwork be given to the office and NOT THE PHYSICIAN.

MEDICAL RECORDS - There is a $50 charge for the release of medical records. Payment is required at the time of the request.

INSURANCE- It is the patient's responsibility to provide the clinic with current insurance information. We ask for your insurance card and a photo id at your first visit to obtain a copy for our records. We may occasionally request a copy at a later date to update your records, so please have your insurance card every time you come to our office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the clinic. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copayments, and non-covered charges and "usual and customary" charges. We will supply information as necessary**. You are ultimately responsible for the timely payment on your account.**

COPAYS- Your copay is due at check in.

NO SHOW FEE- After the second late cancel or no show you will be charged a fee of $25.00. It is important that you are on time to each appointment to ensure that every patient can be seen in a timely manner.

RETURNED CHECKS- The charge for a returned check is $35.00 This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "CASH ONLY" basis following any returned check.

UNPAID BALANCES- This company reserves the right to charge interest on all unpaid balances up to 10% per annum prior to taking a civil judgment. If this debt is not a consumer debt as defined by the UCCC, then client agrees to pay attorney fees and all other costs of collection. If the debt is consumer debt as defined by the UCCC, then consumer agrees to pay attorney fees in an amount not to exceed 15% of the total amount of the debt after default or as otherwise permitted or limited by the UCCC or other laws of the United States or the State of Kansas.

I agree to provide a credit card to Concierge Medi cine of Wichita to charge all past due unpaid balances. Giving this credit card assures the patient that the unpaid balance will not go to collections. Concierge Medicine of Wichita will provide notification of receipts charged on this credit card. If the debt is unable to be cleared by this credit card a collection agency will be consulted.

Name on Card: _____ Credit Card # _____

Type of Card: Visa Mastercard Discover Expiration Date: _____

Signature: _____ Date: _____

If you cannot provide a credit card please complete the ACH form or maintain a $150.00 credit balance on your account to be applied toward future balances due.

***I have read and agree with Concierge Medicine of Wichita Financial Policy**

Printed Name: _____ Date: _____

Patient/Responsible Party Signature: _____

Concierge Medicine of Wichita, LLC
Dr. Aly Gadalla

PATIENT AGREED LIEN

The undersigned, **[PAT_NAME_FMILS]**, (patient) acknowledges by signing below that the patient has made an express request to Concierge Medicine of Wichita, LLC and/or Dr. Aly Gadalla, MD (medical provider) that the patient has a need for a lien to be filed against their personal injury case in order to obtain necessary medical care after their injury. Patient requests that the doctor not bill patient for co-payments or balance owed payments from the patient until the personal injury suit is resolved. Patient requests that medical treatment be performed under a lien agreement. Patient understands that patient must determine whether to use their health insurance (if any) and direct medical provider by signing below. (Must check below on the specific request) Patient agrees that in exchange for medical services provided by medical provider, that he/she will allow a contractual lien against his/her case by medical provider and understands that this will have to be paid out of the proceeds of his/her settlement.

Patient further understands that if the personal injury case does not turn into a positive result that the patient is still responsible for the medical treatment.

He/she directs the firm of _____ to pay medical provider directly from their personal injury settlement at the time the case is settled. The undersigned patient understands that this is a voluntary lien provided to get medical treatment due to the lack of insurance and/or the lack of good health insurance that medical provider is willing to accept. Patient understands that he/she does not have to sign this.

I HEREBY REPRESENT THAT I AM IN NEED OF MEDICAL TREATMENT AND HAVE SUCH SIGNIFICANT PAIN THAT I INDEPENDENTLY CHOOSE TO SIGN THIS LIEN TO GET MEDICAL TREATMENT AND UNDERSTAND THAT NO ONE HAS COERCED OR FORCED ME TO SIGN THIS LIEN AND AGREE THAT IT IS MY FREE AND VOLUNTARY CHOICE AND DECISION TO SIGN THIS.

_____ _____
Patient Date

NOTE TO PATIENT: CHOOSE BELOW AND SIGN ONLY ONE DIRECTION TELLING US TO BILL YOUR HEALTH INSURANCE OR TELLING US TO PLACE ALL TREATMENT ON A LIEN.

** I request that the medical provider submit to my health insurance, Medicare, Medicaid or other form of health insurance and place only liens on the co-pay and balance amounts not paid by insurance.

_____ _____
Patient Date

OR

** I request that the medical provider NOT submit to my health insurance, Medicare, Medicaid or other form of health insurance and expressly acknowledge that I have made this choice voluntarily on my own and understand that I could direct the medical provider otherwise.

_____ _____
Patient Date

The undersigned attorney/law firm agrees to protect the lien solely in the event of a recovery and in no way guarantees the payment of any medical bills of the patient to medical provider.

_____ _____
Attorney/Law Firm Date