Western Missouri Bone and Joint

510 Foster Lane, Suite 101
Warrensburg, MO 64093
Phone: (660) 747-2228 Fax: (660) 747-7677

Patients Full Name: _____ Nickname: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Telephone #: _____ Cell Phone # _____

Date of Birth: _____ SS# _____ Sex: F ☐ M ☐

Race: ____ Ethnic Group: Hispanic ☐ Non-Hispanic ☐ Latino ☐ Marital Status: S – M – D – W (circle)

Patients Employer: _____ Employment Status: Full Time ☐ Part Time ☐

Address/Telephone #: _____ Disabled Date: _____ Retirement Date: _____

Name/Policy # of **Primary** Insurance: _____

Name/Address/Employer of Subscriber: _____

Subscribers DOB: _____ Subscribers SS# _____

Name/Policy # of **Secondary** Insurance: _____

Name/Address/Employer of Subscriber: _____

Subscribers DOB: _____ Subscribers SS# _____

In Case of Emergency

Name/Relationship/Telephone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Would you like to access to your Health Information Online: Yes ☐ No ☐ Email: _____

Who is your Primary Care Physician? _____

What is your Preferred Pharmacy? _____

Illness/Accident Details- Please Be Specific

Was this injury due to an accident, sports injury, fall or surgery? Yes ☐ No ☐

Where did the accident happen? _____

Is litigation pending due to this problem? Yes ☐ No ☐

Were you injured at work? Yes ☐ No ☐

History of present illness: (Be Specific)

Body Part: _____ L—OR—R (CIRCLE ONE) Onset Date: _____

Signature: _____ Date: _____

Western Missouri
MEDICAL CENTER

LATE ARRIVAL/NO SHOW POLICY

Your healthcare is important to us, however we also have other patients in need of our care. Each day we have only a certain number of appointments available during the day. When you schedule an appointment our office staff set aside time for you to be seen. If you arrive late or do not show for your scheduled appointment you may cause someone else to go unseen that could have been scheduled in your unused appointment time.

Patients are seen in order of their appointment time. If you arrive beyond your scheduled appointment time (15 minutes) your physician will be consulted to determine if you can be worked in or if rescheduling your appointment will be necessary.

If you make an appointment and do not show or call to cancel, (we prefer a 24 hour notice), you will receive a letter that states you were a no show. If you miss three appointments in a 12 month period you will be notified by letter and asked to seek your healthcare somewhere else. We hope you will appreciate how important it is to keep your scheduled appointments or give a 24 hour notice to rescheduling.

Please sign below stating that you read and understand this policy. A copy of this notice will be kept on file with date and times of any missed appointments.

Thank you for your understanding and cooperation.

Print Name:_____ **Date:**_____

Patients Signature:_____

Western Missouri
MEDICAL CENTER

Notice of Privacy Practice

Western Missouri Medical Center and certain members of it Medical Staff have elected to be covered by an Organized Health Care Arrangement, as described in the Health Insurance Portability and Accountability Act of 1996. The Organized Health Care Arrangement covers the Medical Center and any entity owned by the Medical Center that provides care to patients and those health care providers on the medical staff who provide care to patients in the Medical Center or facilities owned by the Medical Center. These healthcare providers will share your healthcare information for the purposed of treatment, payment, and healthcare operations as outlined in the Notice of Privacy Practices. The Medical Center and said Medical staff members agree to abide by the terms of the Joint Notice of Privacy Practices created by the Medical Center for all services rendered on Medical Center premises or Medical Owned facilities.

Please list below any individuals you authorize to discuss your medical care with us. The individuals must agree to provide their date of birth and phone number for identification purposes.

Name⬇	Phone #⬇	Date of Birth⬇	Relationship⬇

CONSENT TO CALL OR LEAVE MESSAGES:

Occasionally it is necessary to leave messages regarding the results of testing procedures performed in the office. In an effort to inform you promptly of your test results, please check the box below to indicate how you would prefer us to communicate this information with you

□ Messages regarding test results may be left on my home/cell answering machine.
□ Messages regarding test results may be left with the people I have listed above.
□ You may call me at work. (No messages will be left in any fashion other than instructing you to call the physician's office)
□ No messages regarding test results may be left on my home/cell answering machine. Only a message instructing me to call the physician's office.
□ No messages at all. Contact me directly.
□ Other

DO NOT DISCUSS MY MEDICAL CARE WITH ANYONE OTHER THAN ME._____ (INITIALS)

This consent may be changed or revoked at any time by written notification from me.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of the Notice of Privacy Practice and authorize the use and disclosure of the identified information to the persons and for the purposed described.

Print Name: _____ Date of Birth: _____

Signature of Patient or Legal Representative⬇ Date _____

_____

If signed by legal representative, specify relationship to patient _____