McPherson Medical and Surgical Associates
1000 Hospital Drive
McPherson, Kansas 67460
620.241.7400

General Surgery	*OB/GYN*	*Family Medicine*	
Clayton D. Fetsch, MD, FACS Edward S. Stanton, MD, FACS	Bret E. Heskett, MD, FACOG	David L. Buller, MD Melisa Cooper, PA-C Sheila W. Gorman, MD Dan M. Lichty, MD Jill Sigsbee, PA-C Tracy Sweat, PA-C	Gregory M. Thomas, MD Carl E. Turner, DO Trenton J. VanEaton, MD Nick Vogts, PA-C Autumn Wilgers, NP-C, APRN

New Patient or Transfer Physician Request Form

Patient Name ____

Thank you for your interest in receiving care from one of our outstanding providers at McPherson Medical and Surgical Associates. Below is a listing of our providers. If you have a request for a preference, please denote that or simply check "No Preference" and we will take care of the rest. We work hard to connect you with a provider to meet your individual needs but cannot guarantee a specific provider's availability.

NO PREFERENCE FOR PROVIDER

David Buller, MD

Sheila Gorman, MD

Dan Lichty, MD

Greg Thomas, MD

Carl Turner, DO

Trenton VanEaton, MD

Melisa Cooper, PA-C

Jill Sigsbee, PA-C

Tracy Sweat, PA-C

Nick Vogts, PA-C

Autumn Wilgers, NP-C, APRN

You will receive follow-up communication from our office regarding your request as soon as possible. Please return this form to the Medical Office Building at 1000 Hospital Drive. This does not obligate you to stay with this provider. Thank you for your business.

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Office Use Only

Date Patient Contacted ___________________ Date Received_______________________

McPherson Medical and Surgical Associates
1000 Hospital Drive • McPherson, Kansas 67460

PATIENT INFORMATION (Please Print)

Date: ______________________

Name ______________________ Sex ☐ M ☐ F Age: __________

Address ______________________ Birthdate ______________________

City ______________________ State ________ Zip __________ Phone ____________

Email ______________________ Cell Phone ______________________

Social Security # ______________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employer ______________________ Occupation ______________________

Business Address ______________________ State ________ Zip __________ Phone ____________

If patient is a minor:

Mother's Name ______________________ Primary Phone ____________ Work Phone __________

Father's Name ______________________ Primary Phone ____________ Work Phone __________

RESPONSIBLE PARTY / PRIMARY INSURANCE INFORMATION

Insured's Name ______________________ Relation to Patient ______________________

Insured's Birthdate ____________ Social Security # ______________ Work Phone ____________

Insured Employed by ______________________ Address ______________________

Insurance Company ______________________ Group # ____________ ID# ____________

Insurance Address ______________________ City ________ State ________ Zip __________

Do you have additional insurance: ☐ Yes ☐ No If yes, please complete the following:

Insured's Name ______________________ Relation to Patient ______________________

Insured's Birthdate ____________ Social Security # ______________ Work Phone ____________

Insured Employed by ______________________ Address ______________________

Insurance Company ______________________ Group # ____________ ID# ____________

Insurance Address ______________________ City ________ State ________ Zip __________

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment. I hereby assign payments for all medical services rendered to McPherson Medical and Surgical Associates.
I acknowledge that I am responsible for payment for all charges incurred that may not be covered due to a required co-payment, insurance deductible or classified by my insurance as non-covered services.

Signature ______________________ Relationship ______________ Date ______________

Notice: Your health information related to work-related illnesses or injuries or medical surveillance of the workplace may be disclosed to your employer.

ACKNOWLEGMENT OF RECEIPT OF PRIVACY PRACTICES
I hereby acknowledge that I have received a copy of the McPherson Hospital Notice of Privacy Practices.

Signature ______________________________________ Date ______________

McPherson HOSPITAL

NEW PATIENT HEALTH HISTORY FORM

Today's Date: ____________________

Name (Last, First MI)	Date of Birth

Present Health Concerns:

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis.

☐ Blood Clots	☐ Asthma	☐ High Blood Pressure
☐ Cancer	☐ Hearing Loss	☐ Migraine Headaches
Type:	☐ Heart Problems	☐Stroke
Date:	☐ Valvular (mitral/aortic)	☐ Thyroid Problems
☐ Concussion	☐ Rhythm (a-fib)	
☐ Depression	☐ Blockage (heart attack)	☐ Other
☐ Diabetes	☐ Other	
☐ Type I		
☐ Type II	☐ High Cholesterol	

Surgical History: (Please list all other prior operations and dates)

Operation	Date	Operation	Date

Procedure History: (Please list all prior procedures and dates, i.e. Colonoscopy, Bone Density Scan, Heart Cath, Stress Test)

Procedure	Date	Procedure	Date

Women's Gynecological History:

# of Pregnancies	# of Deliveries	# of Abortions	# of Miscarriages
1st day of most recent period	Age at 1st period	Frequency of periods	Length of each
Last Pap Smear Abnormal ☐ Yes ☐ No Date:		Last Mammogram Abnormal ☐ Yes ☐ No Date:	

McPherson HOSPITAL

Family History:

Relative	Year of Birth	Age of Death	Cause of Death	**Health Issues** (diabetes, high blood pressure, depression, cancer, etc.)
Father				
Mother				
Siblings (Please circle one)				
Brother / Sister				
Brother / Sister				
Brother / Sister				
Maternal Grandmother / Grandfather				
Paternal Grandmother / Grandfather				
Other				

Social History:

Occupation:	Marital Status (Circle One) Single / Married / Widowed / Divorced
Advance Directives: ☐ DNR ☐Living Will ☐Power of Attorney ☐ Living Arrangements Caffeine Intake: ☐ Never ☐ Occasional ☐ Daily	Alcohol Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Prior Use Quit Date: ______________________________ Amount per week: ___________________________________
Tobacco: ☐ Current – Type :___________ Freq: ________ ☐ 2nd Hand ☐ Never ☐ Prior Use Quit Date: ___________________________	Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use ☐ Prior Use Quit Date: ______________________________ History of Drug Abuse: _______________________________

Medications: Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs. If more space is needed you can attach a list. **BRING ALL OF YOUR MEDICATIONS TO YOUR FIRST APPOINTMENT.**

Medication	Dose	Times per day	Medication	Dose	Times per day

Allergies or Reactins to Medicines / Food / Other Agents: ☐ Check if no allergies

Medication	Reaction or Side Effect

Immunizations: Please list your most recent immunizations and date received. **PLEASE BRING A COPY OF YOUR IMMUNIZATIONS TO YOUR FIRST APPOINTMENT.**

☐ Hepatitis A:	☐ Measles/Mumps/Rubella (MMR):	☐ Gardasil:
☐ Hepatitis B:	☐ Pneumovax (Pneumonia):	☐ Pertussis (Tdap):
☐ Tetanus Td:	☐ Varicella (Chicken Pox):	☐ Shingles
☐ Flu Vaccine:	Other:	Other:
☐ TB Skin Test:		

Notice of Privacy Practices

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

McPherson Hospital provides healthcare services and products to those we serve in cooperation with physicians and other professionals and organizations involved in your care. Our privacy practices govern the following:

- Healthcare providers and professionals at our facility;
- Workforce, students, and volunteers at our facility; and
- Business Associates with whom we share your protected health information ("PHI").

McPherson Hospital Responsibilities

We are required by law to:

- Maintain the privacy of your PHI;
- Notify you in the event of a breach of your unsecured PHI;
- Provide you this notice of our legal duties and privacy practices with respect to PHI;
- Abide by our current Notice of Privacy Practices ("NPP"); and
- Follow the more stringent state law or federal law.

We must obtain your written authorization prior to:

- Selling your PHI, except when permitted by law;
- Use or disclosure of your PHI for marketing purposes that involve financial remuneration to us, except for face-to-face communications made by us to you or a promotional gift of nominal value provided by us to you;
- Use or disclosure of any psychotherapy notes, except for: use by the originator of the psychotherapy notes for treatment; use or disclosure for our own mental health training programs; or use or disclosure to defend ourselves in a legal action or other proceeding; and/or
- Other uses and disclosures not described in this NPP.

Permissible Uses and Disclosures of PHI:

- We are permitted to use and disclose PHI for treatment. For example, we may provide PHI to another provider such as a specialist as part of a referral or another provider who has been asked to be involved in your care.
- We are permitted to use and disclose PHI to obtain payment for treatment. For example, we may send PHI as part of the billing information to your insurance company or payer.
- We are permitted to use and disclose PHI for use in healthcare operations. For example, we may use PHI to improve quality of our care or operations or to evaluate our staff's performance while caring for you.
- Subject to certain limitations, we are permitted to use and disclose PHI without your prior authorization for: public health purposes; reporting on abuse, neglect, or domestic violence; health oversight activities; coroner and funeral arrangements; organ donations; law enforcement activities; research purposes; workers' compensation purposes; healthcare services provided at the request of an employer; student immunization

reporting; specialized government functions; prevention of serious threats to health or safety; judicial and administrative proceedings; or when required by federal, state or local law.

- We are permitted to contact you for appointment reminders or to inform you about treatment options, alternatives, health-related benefits, or services that may be of interest to you.
- Unless you object, we list your name, room number, location, general condition (good, fair, etc.), and religious affiliation in the census report and your religious affiliation may be disclosed to a clergy member.
- We are permitted to disclose PHI to a friend, family member, or other individual who you identify as being involved in your medical care or payment for care. In situations where you are incapacitated or unable to make this decision, we will use our professional judgment in making such disclosures.
- We are permitted to disclose PHI to disaster relief authorities, so that your family may be notified of your location and condition.

Your Rights and Responsibilities Regarding PHI:

- In most cases, you have the right to review or obtain a copy of your PHI by submitting a written request. If you request a copy, either paper or electronic, we may charge a reasonable fee for this service. If your request is denied, you may submit a written request for review of that decision.
- If you believe information in your record is incorrect or missing, you may request an amendment to the record by submitting a written request. If your request is denied, you may appeal, in writing, the decision not to amend a record. You may also ask that your written statement requesting an amendment be placed in your medical record.
- You have the right to request an accounting of the disclosures of your PHI made outside of our facility. This does not include the permitted disclosures for treatment, payment, and healthcare operations. The request must state the time period desired for the accounting of disclosure, but no more than six years prior to the current date. You may request the accounting be provided in paper or electronic form. You may request that we transmit a copy to a third party designated by you. One accounting of disclosure in a 12-month period is free; additional requests are billed based on the cost of production. We will inform you of the fee for this service before any charges occur.
- You have the right to request restrictions on how we use and disclose your PHI. We are not required to comply with these requests. However, we are required to comply with any request to restrict PHI disclosed to a health plan about a healthcare service or product for which you, or someone other than the health plan, paid us out of pocket and in full prior to the involved healthcare service or product being rendered. If we accept a restriction request, we abide by it except when a use or disclosure is necessary for emergency treatment or is required by law.
- You have the right to revoke any previous authorizations, except to disclosures made prior to the date of revocation, by notifying us in writing of your decision.
- You may request that we communicate with you in a specific manner.
- You may opt-out of any current and future fundraising communications as explained in those communications or by completing the Fundraising Opt-Out form. We do not condition treatment or payment on your acceptance of fundraising communications.
- If you obtained this NPP electronically, you have the right to a paper copy.

Electronic Health Information Exchange

McPherson Hospital participates in the electronic exchange of health information with other healthcare providers and health plans in the State of Kansas through an approved health information exchange organization. Through our participation, your PHI may be accessed by

other providers and health plans for the purposes of treatment, payment, or healthcare operations. This health information exchange organization maintains appropriate safeguards to protect your PHI.

Under Kansas law, you have the right to decide whether providers and health plans can access your health information maintained at a health information exchange (“HIE”). You have two choices. You can permit authorized individuals to access your PHI maintained at an HIE for treatment, payment, or healthcare operations. If you choose this option, you do not have to do anything.

You can choose to restrict access to your PHI maintained at an HIE by submitting the required form to the Kansas Health Information Exchange at www.khie.org. Your restriction does not prevent access by authorized individuals to your PHI maintained by an HIE for purposes of obtaining information about certain communicable diseases, suspected incidents of abuse, or in an emergency. Your decision to restrict access of your PHI maintained at an HIE does not prevent permissible uses and disclosures of your PHI, outside of an HIE, by McPherson Hospital as outlined in this notice. Additional information regarding electronic health information exchanges is available at www.khie.org.

Shared Health Information

In addition to the HIE, McPherson Hospital participates in Organized Health Care Arrangements and acts as an Affiliated Covered Entity with healthcare providers, who have agreed to work with each other to facilitate access to health information that may be relevant to your care. For example, if you are admitted to a hospital on an emergency basis and cannot provide important information about your health condition, these arrangements will allow us to make your health information available to those who need it to treat you. When it is necessary, ready access to your health information means better care for you. We store health information about our patients in an electronic medical record with other healthcare providers who participate in the arrangement. You may contact the Privacy Officer for a list of healthcare providers who participate in these arrangements.

Privacy Practices Notice

McPherson Hospital reserves the right to change its NPP at any time. Changes apply to PHI we already maintain. When we make a significant change to our policies or privacy practices, we post the new NPP in clear and prominent locations in our facility and on our website at www.mcphersonhospital.org. You may request a copy of the current NPP at any time. The NPP is provided no later than date of first service. McPherson Hospital may request that you provide written acknowledgement that you received this NPP.

Who to Contact:

- Written requests or appeals should be submitted to the Privacy Officer listed below.
- If you wish to file a complaint because you believe that your privacy rights may have been violated, please contact the Privacy Officer.
- You also may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.
- Retaliation and retribution for making complaints or raising concerns are prohibited.

Privacy Officer, McPherson Hospital
1000 Hospital Dr.
McPherson, KS 67460
620.241.2250

U.S. Dept of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201