KANSAS PAIN MANAGEMENT
10995 QUIVIRA ROAD, OVERLAND PARK, KS 66210
Phone: 913.339.9437 Fax: 913.339.9538

PATIENT HEALTH INSURANCE

***** Current Insurance Cards and Driver's License Must Be Presented to Front Desk For Each Appointment and Copayment Made Prior to Being Seen By Provider *****

		PATIENT NAME	
TODAY'S DATE		DATE OF BIRTH	

PRIMARY INSURANCE INFO

COMPANY NAME			NEED REFERRAL		YES	NO
ADDRESS			MEDICARE MANAGED CARE		YES	NO
CITY		STATE		ZIP CODE		
WORK TEL. 1		ELIG PAYOR ID				
FAX		PROF PAYOR ID				
EMAIL						
PLAN ID		PLAN NAME				
GROUP NO.		STATUS	ACTIVE	NON-ACTIVE		
GROUP EMPLOYER NAME						
SUBSCRIBER ID		EFFECTIVE FROM		UP TO		
RELATION	SELF SPOUSE PARENT	LEGAL GUARDIAN	OTHER:			
FIRST NAME		MIDDLE		LAST NAME		
SEX		DOB				
ADDRESS				SAME AS PATIENT	YES	NO
CITY		STATE		ZIP CODE		
SSN						
COPAY AMOUNT		CO-INSURANCE AMOUNT				
DEDUCTIBLE						

SECONDARY INSURANCE INFO

COMPANY NAME			NEED REFERRAL		YES	NO
ADDRESS			MEDICARE MANAGED CARE		YES	NO
CITY		STATE		ZIP CODE		
WORK TEL. 1		ELIG PAYOR ID				
FAX		PROF PAYOR ID				
EMAIL						
PLAN ID		PLAN NAME				
GROUP NO.		STATUS	ACTIVE	NON-ACTIVE		
GROUP EMPLOYER NAME						
SUBSCRIBER ID		EFFECTIVE FROM		UP TO		
RELATION	SELF SPOUSE PARENT	LEGAL GUARDIAN	OTHER:			
FIRST NAME		MIDDLE		LAST NAME		
SEX		DOB				
ADDRESS				SAME AS PATIENT	YES	NO
CITY		STATE		ZIP CODE		
SSN						
COPAY AMOUNT		CO-INSURANCE AMOUNT				
DEDUCTIBLE						

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE, COMPLETE AND TRUE. I GIVE MY CONSENT TO ANESTHESIOLOGY PROFESSIONALS, PA, DBA KANSAS PAIN MANAGEMENT TO RETRIEVE AND REVIEW MY MEDICAL AND MEDICATION HISTORY. I UNDERSTAND THIS WLL BECOME PART OF MY MEDICAL RECORD. I hereby give lifetime authorization for payment of insurance benefits to be made to Anesthesiology Professionals, PA, dba Kansas Pain Management, 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 even of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be a valid as the original.

PATIENT'S PRINTED NAME		DATE	
PATIENT'S SIGNATURE		RELATIONSHIP TO PATIENT	
*LEGAL REPRESENTATIVE'S PRINTED NAME		DATE	
*LEGAL REPRESENTATIVE'S SIGNATURE			

*If signing as the legal representative, I represent to Anesthesiology Professionals, PA, dba Kansas Pain Management, that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to Anesthesiology Professionals, PA.