

CenterPointe
Physicians, P.A.

Segen Chase, MD
Matthew Floersch, MD
Lan Ly, MD
Chance Williams, MD
Quincie Keesecker, APRN-C
Heather Sloan, APRN-BC

PERSONAL / INSURANCE INFORMATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PHONE: (HOME) _____ (CELL) _____ (WORK) _____

SOCIAL SEC #: _____ DATE OF BIRTH: _____

CHOSEN GENDER IDENTITY: MALE / FEMALE SEX ASSIGNED AT BIRTH: MALE / FEMALE

E-MAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

RACE: AFRICAN AMERICAN CAUCASIAN HISPANIC/LATINO DECLINE
OTHER _____

PREFERRED LANGUAGE: ENGLISH SPANISH DECLINE
OTHER _____

LOCAL EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER DATE OF BIRTH _____

ADDRESS (IF DIFFERENT FROM PATIENT): _____

CITY _____ STATE _____ ZIP _____

CELL PHONE: _____



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Personal Health History

Today's Date: _____

Name: _____

Date of Birth _____ - _____ - _____

Allergies or Drug Reactions: None Known
 Penicillin Sulfa Erythromycin Other: _____

Medications:	Name	Dose	Times a Day	Name	Dose	Times a Day
1)	_____	_____	_____	6)	_____	_____
2)	_____	_____	_____	7)	_____	_____
3)	_____	_____	_____	8)	_____	_____
4)	_____	_____	_____	9)	_____	_____
5)	_____	_____	_____	10)	_____	_____

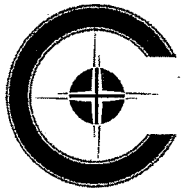
Past Medical History: High Blood Pressure Heart Attack Sleep Apnea Heart Failure Diabetes
 Stroke Colitis High Cholesterol Seizures Migraines Asthma Emphysema
 Reflux Gout Kidney Disease Peptic Ulcers Arthritis Allergies Depression
 Panic Attacks Hypothyroid Chronic Pain _____ Broken Bone _____
 Cancer _____ Other: _____

Past Surgeries: Gall Bladder Appendix Tonsils & Adenoids Hysterectomy Heart Bypass/Stent
 Other _____

Hospitalizations: _____

Family History	High Blood Pressure	Diabetes	Stroke	Heart Attack	Cancer	Type of Cancer	Depression	Substance Abuse	Other	Alive	Deceased
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Immunizations (Circle): Tetanus <5yrs <10yrs >10yrs Shingles - Y / N Pneumovax 23 - Y / N Prevnar 13 - Y / N
 COVID 19: Y / N Brand _____ Date(s) Given _____



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FINANCIAL POLICY

Thank you for choosing CenterPointe Physicians PA for your healthcare needs. In order to best serve you, our patient, we have outlined our financial policy below.

Copay: Applicable copayments are to be paid at the time services are rendered. Accepted forms of payment include cash, check, money order, Visa, and Mastercard.

Patient Responsibility: Patients are responsible for providing current, accurate personal and insurance information in order for insurance claims to be filed. Every effort will be made to obtain insurance payment, however it may be necessary for patients to become involved in this process. This office will contact patients as these instances arise.

This office makes every effort to correctly submit charges to insurances. The office sees patient healthcare as a partnership and aims to properly submit patient bills. However, rules are ever changing with the new healthcare reform and if you are ever billed for a service ordered, and feel this is incorrect, please contact the office.

Please remember that insurance is a contract between patients and insurance companies, and ultimately patients are responsible for payment of outstanding balances whether or not they have insurance.

Self Pay: Self pay patients are expected to pay for services at the time rendered. A 10% discount will be given for payment at time of service. If payment in full cannot be made, 50% must be paid at time of service with the remaining balance paid within 30 days, with no applicable discount.

Outstanding Balances: Outstanding balances are to be paid in full within 30 days of receipt of a statement. If this is not possible, an arrangement for payment can be made by calling (785) 537-4940 ext. 2 and speaking with the billing manager. Accounts may be referred to an outside collection agency when no contact from the patient is received or effort is made to pay the balance within 90 days after initial bill has been sent and unanswered. Upon referral to collections, the patient may also be dismissed from the practice.

Appointments: If patients are unable to keep their appointment please notify our office as soon as possible, 24 hours notice to our office is requested for scheduling purposes. Patients who do not contact our office and do not keep an appointment may be charged \$20 each appointment that is not kept. This is a fee that is not covered by insurance and will be the responsibility of the patient.

Returned Checks: There will be a fee of \$25 on all returned checks.

Questions: Any questions or concerns may be addressed with the billing manager who can be reached at (785) 537-4940 ext. 2.

I authorize the release of any medical information necessary for billing or to process insurance claims. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED CHARGES.

SIGNATURE

DATE

Patient Health Questionnaire (PHQ-9)

Name _____

Date _____

	Not at all	Several Days	More than half the days	Nearly every day
Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?				
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble fall/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself of that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that CenterPointe Physicians, PA has provided me a copy and I have had an opportunity to receive a copy of their **NOTICE OF PRIVACY PRACTICES**.

Signature

Date



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Name: _____

Today's Date: _____

Review of Systems: Please check if you experience the listed symptom.

General/Constitutional: change in appetite chills fatigue fever headache night sweats weight loss

Allergy: congestion hives seasonal allergies (circle) Spring Summer Fall lip/tongue swelling

Ophthalmologic: blurred vision eye pain red eye vision loss

ENT: tooth pain decreased hearing ear pain nosebleed sinus pain sore throat

Endocrine: cold intolerance excessive thirst heat intolerance

Respiratory: snoring cough wheezing

Cardiovascular: leg swelling chest pain at rest chest pain with exertion
 difficulty laying flat palpitations shortness of breath

Gastrointestinal: abdominal pain blood in stool constipation diarrhea
 difficulty swallowing heartburn/reflux nausea vomiting

Hematology: easy bruising prolonged bleeding swollen glands

Women Only: breast lump discharge from breast irregular menses painful intercourse vaginal discharge/itch

Men Only: testicular lump testicular pain difficulty initiating stream penile discharge erectile dysfunction

Genitourinary: blood in urine painful urination urinate at night (how many times? ____) urine leakage

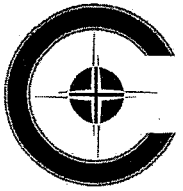
Musculoskeletal: injury (what? _____, when? _____) leg cramps
 muscle ache (where? _____) painful joints (where? _____)
 swollen joint (where? _____) muscle weakness

Peripheral Vascular: varicose veins cold extremities pain/cramping in legs after exertion ulceration of feet

Skin: hair changes acne rash (where? _____) sore or lesion or bump (where? _____)

Neurologic: balance difficulty dizziness fainting loss of strength memory loss
 pain seizures tingling/numbness tremor

Psychiatric: anxiety difficulty sleeping suicidal thoughts



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Social History

Do you use tobacco? current smoker former smoker chewing tobacco nontobacco user

If 'current smoker': How often do you smoke cigarettes?

everyday some days, but not every day

If 'current smoker': How many cigarettes a day do you smoke?

5 or less 6-10 11-20 21-30 31 or more

If 'current smoker': How soon after you wake up do you smoke your first cigarette?

within 5 minutes 6-30 minutes 31-60 minutes after 60 minutes

If 'current smoker': Are you interested in quitting?

Ready to quit Thinking about quitting Not ready to quit

If 'chewing tobacco' how many cans per day? _____

Do you vape? yes no

Are you exposed to second hand smoke? yes no

Do you ever drink alcohol? yes no

If 'yes': How many drinks do you have in a day?

none 0-1 1-2 3-5 more than 5 binge drinker

Do you exercise? yes no

If 'yes': How many times a week do you exercise?

occasional 1-2 2-3 3-4

Are you sexually active? yes no

If 'yes', number of partners in the last year _____

Who else lives in your home? spouse parents children none other _____

Do you feel safe in your home? yes no

Have you had a dental evaluation in the last 12 months? yes no

Have you had an eye exam in the last 12 months? yes no If yes, where? _____



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Family and Other Individuals Involved in Your Care

During the provision of your medical care, it may be necessary for the staff of CenterPointe Physicians, PA to communicate with your family members or other individuals involved in your care. To assist us in identifying appropriate individuals, we ask that you provide information regarding people to whom we may communicate (If you want to limit information provided to these individuals please specify below, otherwise we will assume all appropriate information is permissible):

Name of Individual	Relationship	Type of Information
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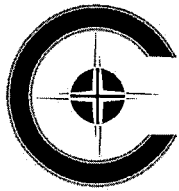
SPOUSE

CHILD

Name Printed

Signature

Date



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: CenterPointe Physicians PA

Address: 2331 Tuttle Creek Blvd

City: Manhattan State: KS Zip Code: 66502

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhoea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without my authorization. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this authorization is voluntary, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information disclosed under this authorization might be redisclosed to the recipient (except as noted above), and this redisclosure may no longer be protected by federal or state law.