CenterPointe
Physicians, P.A.

Segen Chase, MD
Matthew Floersch, MD
Chance Williams, MD
Jennifer Peterson, 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:_____ SEX: 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:_____

HOME PHONE:_____ WORK PHONE:_____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT:_____ RELATIONSHIP:_____

DATE OF BIRTH _____ SSN _____

ADDRESS (IF DIFFERENT FROM PATIENTS): _____

CITY_____ STATE _____ ZIP _____

HOME PHONE:_____ WORK PHONE:_____

INSURANCE COMPANY NAME: _____

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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	□	□	□	□	□		□	□		□	□
Mother	□	□	□	□	□		□	□		□	□
Sister	□	□	□	□	□		□	□		□	□
Brother	□	□	□	□	□		□	□		□	□
Grandfather	□	□	□	□	□		□	□		□	□
Grandmother	□	□	□	□	□		□	□		□	□
Other	□	□	□	□	□		□	□		□	□

Immunizations (Circle): Tetanus <5yrs <10yrs >10yrs Shingles - Y / N Pneumovax 23 - Y / N Prevnar 13 - Y / N

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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 may 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?_____

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?_____

Patient Health Questionnaire (PHQ-9)

Name_____ Date_____

Over the *last2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble fall/staying asleep, sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself of that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

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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

1133 College Ave, Suite D200, Manhattan, KS 66502 – 785.537.4940 / fax 785.537.0836

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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*

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Patient Portal Instructions

Once you have signed up with our office staff to be set up with the patient portal you will receive an e-mail from reminders@eclinicalmail.com at the e-mail address you have provided this office. Within the e-mail will be a link with the website address (https://health.eclinicalworks.com/drfloersch) you will want to save this link to your favorites so you can easily access it again. The e-mail will contain your username and a temporary password. You will be prompted to change your password the first time you login, and set up a security question.

There is an app available for iPhone and Android devices: Healow.

Please call our office with any questions or concerns regarding the patient portal.

Please fill out the following to authorize our office to set up your patient portal account:

Patient name_____ DOB_____

Email_____

Verify Email_____

By signing this you are giving your physician and staff permission to set up a patient portal account, using the provided e-mail address.

_____
Signature

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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 Segen Chase, M.D. and Matthew W. Floersch, M.D. 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
	SPOUSE	
	CHILD	

Name Printed	Signature	Date

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PERMISSION TO ACCOMPANY A MINOR

I give permission to the listed individuals to accompany my child and authorize treatment for my child. This includes bringing the child into the office, providing a history of present illness, disclosing protected health information, and witnessing any physical exam completed by the provider. These adults have the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian. I agree to be available by phone and to be financially responsible for all copay, coinsurance, and deductible amounts.

This authorization is in effect until a new PERMISISON TO ACCOMPANY A MINOR form is completed and signed.

Name of Individual Relationship to Minor

_____

_____

_____

_____

_____

_____
Name of Patient

_____
Name of Parent/Guardian Signature Date

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