SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

ADULT PATIENT DEMOGRAPHIC FORM

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Full Legal Name

Last:	First:	Middle Initial:

Preferred Name/Nickname:	Social Security Number:	Date of Birth:	Sex:
	- -	/ /	☐ Male ☐ Female

Race:
☐ African American/Black ☐ Asian ☐ White
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander
☐ American Indian or Alaska Native ☐ Other _____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Street Address / PO Box:	Lot / Apt #:	City:	State:	Zip Code:

Primary Phone #:	Cell/Mobile?	Secondary Phone #:	Cell/Mobile?
( )	☐ Yes ☐ No	( )	☐ Yes ☐ No

Email Address:	Preferred Language:

How were you referred to or how did you discover KU Wichita MPA Clinics?

Patient Guardian Full Name (If Applicable)	Relationship:	Phone #:	City & State:
		( )	

CURRENT HEALTHCARE PROVIDER INFORMATION

Primary Care Physician/Provider:	Referring Physician/Provider:

Preferred Hospital:	Preferred Pharmacy:

CURRENT EMPLOYMENT/STUDENT STATUS

Employer:	Employment Status:	Student Status:
	☐ FT ☐ PT ☐ Self ☐ Military ☐ Unemployed ☐ Retired ☐ Disabled	☐ FT ☐ PT ☐ Not a Student

Employer Address:	Employer Phone:	Name of School:
	( )	

BILLING/INSURANCE INFORMATION

Primary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

Secondary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

HIPAA CONTACTS - AUTHORIZED REPRESENTATIVES

By listing contacts below, you authorize our office to communicate with them regarding your health, treatment, and billing under HIPAA. ☐ No HIPAA Contacts

Name:	Relationship:	Phone #:
Name:	**Relationship:**	**Phone #:**

EMERGENCY CONTACTS

Someone we may contact in an emergency or if you're unreachable, but are not authorized to receive your medical information. ☐ No Emergency Contacts

Primary Emergency Contact Full Name:	Relationship:	Phone #:	City & State:

Signature of Patient, Responsible Party, or Authorized Legal Representative

Date

Printed Name of Patient, Responsible Party, or Authorized Legal Representative

Relationship to Patient

ESTABLISHED PATIENT CONSENT, AUTHORIZATION, AND DISCLOSURE

Consent for Treatment

I voluntarily consent to receive outpatient medical care at UKSM-W Medical Practice Association (MPA). This includes evaluation, diagnosis, and treatment by licensed healthcare professionals. I understand that I have the right to be informed about my care, including potential risks and alternatives, and that I may revoke this consent in writing at any time.

Telehealth Services

I consent to receive care through telehealth, which may include video or audio-only visits. I understand that:

- Technical issues may affect the quality or timing of care
- HIPAA and privacy laws apply to all telehealth services
- My physician and provider will not record sessions without my permission
- I may withdraw consent at any time without affecting future care
- I may be responsible for charges not covered by insurance

Artificial Intelligence (AI) Dictation Technology

To support accurate documentation, my physician and provider may use HIPAA-compliant, AI-powered dictation technology to transcribe verbal information into text for inclusion in your medical record.

- Audio is deleted within 7 days and not used for clinical decisions
- My physician and provider reviews and confirms all AI-generated notes
- My information is protected by encryption and access controls
- I may request to opt out of AI dictation before my visit

Valuables Disclaimer

I understand that the clinic is not responsible for lost, stolen, or damaged personal items. I am advised not to bring valuables to appointments.

Financial Responsibility & Insurance Authorization

I authorize UKSM-W MPA to bill my insurance and release necessary information to process claims. I accept financial responsibility for any charges not covered by insurance.

Good Faith Estimate

If I am a self-pay patient, I may request a Good Faith Estimate of expected charges before treatment. I may choose to proceed or decline care based on this estimate and my financial situation.

Non-Discrimination Notice

UKSM-W MPA complies with federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. Free aids and language services are available. Contact our Compliance Officer at 316-293-3549 for assistance or to file a grievance.

Patient Name *(Print)* _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name *(Print)* _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

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CONSENT TO COMMUNICATE ELECTRONICALLY

What types of communication could be sent to me?

University of Kansas School of Medicine – Wichita Medical Practice Association "UKSM-W MPA" may send messages regarding your care, such as:

- Appointment reminders and scheduling updates
- Billing and payment notices
- Health-related information or education
- Feedback requests about your visit or services

How might I receive communications?

You may receive communications through one or more of the following:

- Email Notifications
- Text message (SMS)
- Phone or Voice over Internet Protocol (VoIP).

Some messages may be sent using automated dialing systems or include prerecorded/artificial voice.

Will the communications be secure?

Most emails will be encrypted. However, some emails or text messages containing limited personal information may not be encrypted and could pose a security risk. While the likelihood of interception is low, unencrypted messages may be accessed by unauthorized parties. By consenting to electronic communication, you acknowledge and accept this risk. UKSM-W MPA will take reasonable steps to protect your information but cannot guarantee complete security of unencrypted messages.

Are there any costs to me?

Standard text messaging or data rates may apply depending on your mobile plan. Please contact your wireless carrier for details.

What if I do not want to receive these communications?

You are not required to consent to receive electronic communications. You may opt out at any time by:

- Replying "STOP" to any text message
- Clicking "Unsubscribe" on any email
- Contacting your UKSM-W MPA clinic directly

Your preferences will remain in effect unless you update them or give a different type of consent for a specific clinic service or communication platform (such as a patient portal).

Consent Options (Select One):

☐ **I ACCEPT** – I consent to receive electronic communications from UKSM-W Medical Practice Association.

☐ **I DECLINE** – I do not wish to receive electronic communications at this time.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

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ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

As a patient of UKSM-W Medical Practice Association (MPA), you have the right:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To participate in creating a care plan and in making decisions that affects your care.
- To be informed about services and options available to you, including the cost.
- To have your personal information and medical records be treated confidentially.
- To communicate in a language you can understand.
- To consent or refuse to participate in any proposed research study without retribution or difference in the quality of your care.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

PATIENT RESPONSIBILITIES

As a patient of UKSM-W MPA, you have the responsibility:

- To treat other patients and staff of this clinic with respect and courtesy.
- To protect the confidentiality of other patients you encounter in this clinic.
- To participate as much as you are able in creating a care plan, asking questions until you fully understand your care plan, and participating in decision-making that affects your care.
- To let your physician and provider/care team know any concerns you may have about your care plan or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible, to call to cancel or change an appointment time.
- To keep clinic informed of changes in your personal information, including address, phone number, or insurance to ensure timely processing of bills and to promptly meet your financial obligations.
- To provide accurate information to your physician and provider/care team about your symptoms, past illnesses, hospitalizations, medications, and behaviors that may affect your health.
- To follow your care plan and tell physicians and nurses about any obstacles you may encounter in continuing your care plan.
- To consent to a blood test if any healthcare worker should come in contact with your blood.
- To follow clinic rules, such as our no-smoking policy and clinic expectations for patient and visitor behavior, which includes refraining from the use of profanity; verbally abusive, offensive, and/or sexually suggestive language; threatening statements or any act or threat of inappropriate behavior.

I acknowledge that I have reviewed and understand these rights and responsibilities, and I understand that my signature below means that I am agreeing to do my part to respect the clinic's policies and to help create a safe, healing environment. I understand that failure to comply with the terms of this Agreement may prevent me from continuing to receive care from the clinic.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL-BASED HEALTH CARE
AUTHORIZATION FOR BILLING AND HEALTH INFORMATION RELEASE

CONSENT TO BILL INSURANCE AND RESPONSIBLE PARTY

I understand that the health clinic needs to cover its expenses and therefore bills for services rendered. This includes billing third parties such as any applicable health insurer. I further understand that that I, as the patient or the responsible party for the patient, will be billed directly for health services provided by KU Wichita Pediatric / School-Based Health Care that are not covered by my insurer.

I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred not covered by my insurance. UKSM Wichita Medical Practice Association will produce a "Good Faith Estimate" if requested by the self-pay patient/guardian. Good Faith Estimates provide a quote for the cost of treatment prior to services being performed. Patient may authorize the physician and provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act can be provided to the patient upon request.

Patient statements will be generated after UKSM Wichita Medical Practice Association has received payment from your insurance company. Methods of communication, including but not limited to, email and text messages, may be used to contact a patient regarding their balance. Patients are automatically opted-in for voice messages, text messages, and email reminders regarding their balance. To opt-out, please provide verbal or written notice to a UKSM Wichita Medical Practice Association receptionist or the business office. If I have concerns regarding billing, I understand that I should contact KU Wichita Medical Practice Association at (316) 293-3429 and not KU Wichita Pediatric / School-Based Health Care or the school where health services were provided.

CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes release of medical information. This information may be shared for:
(1) the patient's treatment, including disclosure to school personnel involved in a student's health care—including but not limited to the school nurse, health aide, social worker, counselor, and mental health care provider on campus—to the extent required to provide quality, comprehensive medical care. For adult patients health information will not be disclosed to school personnel unless specifically authorized by the patient or permitted by law; and
(2) for billing and payment purposes.

I acknowledge I have received a copy of KU Wichita Medical Practice Association's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that KU Wichita Medical Practice Association may change its privacy practices in the future, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact KU Wichita Medical Practice Association's Privacy Officer with any questions I may have about the Notice of Privacy Practices.

In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of the patient's health information for the purposes described in the Notice of Privacy Practices. In addition to the above, information about the patient may be shared as part of reporting child or adult abuse and/or neglect or other exceptions included in Kansas law.

CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the consent for release of health information. My signature indicates my consent to release medical information as specified.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature (student if 18 years or older or otherwise permitted by law) _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

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SCHOOL-BASED HEALTH CARE
ACKNOWLEDGEMENT OF POLICIES

University of Kansas School of Medicine – Wichita Medical Practice Association ("MPA") has made updates to the following policies:

- **Notice of Privacy Practices** - *Revised December 2025*
- **Notice of Non-Discrimination** - *Revised December 2025*

Printed copies of each policy are available upon request at the front desk. Please sign below to acknowledge that you have been informed of these policy updates and have had the opportunity to review or request a copy.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature (student if 18 years or older or otherwise permitted by law) _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____