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Fellows, American Academy of Family Practice and American College of Physicians

305 S. Platte Clay Way, Kearney, Missouri 64060 P 816-628-4409 F 816-628-5783

libertyhospital.org

Dear Patient,

Welcome to The Kearney Clinic, an affiliate of Liberty Hospital. We are excited that you have chosen us for your healthcare needs and we look forward to working with you toward your healthcare goals.

Enclosed you will find several pieces of information about The Kearney Clinic. Please take a minute to read the brochures and complete the New Patient Forms.

Demographic Sheet

Please complete the two pages with your personal information. We will input this information into your electronic health record and update it on an annual basis.

Medical Records Release

We request that you have any past medical records forwarded to our office. Please complete the release so we can send it to your previous provider for us to be able to review your records.

Privacy Policy & HIPAA

The Notice of Privacy Practices brochure is enclosed for you to read. Please sign the acknowledgment that you have received and read the information. The HIPAA form allows you to list those persons with whom we may share some of your personal health information (PHI). You determine what and with whom we may share.

Financial Policy and Billing Information

If you have medical insurance, please bring ALL of your current insurance cards with you to the appointment. We will file a claim with your health insurance and notify you of any balance which may be due. Any amount not paid by your insurance company will be considered patient responsibility. Co-pays are collected at the time of your appointment, so please come prepared with your co-pay amount. Patients without health insurance are also required to pay at the time of service. Please read and sign the Financial Policy.

If you have any questions or concerns, please let us know.

We are located at 305 S. Platte Clay Way, Kearney, MO 64060.

Our office hours are: 8:00 a.m. to 5:00 p.m. Monday, Tuesday, Thursday and Friday, and 7:30 a.m. to 7:00pm on Wednesdays.

Sincerely,

The Kearney Clinic Providers and Staff



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Comprehensive Health Assessment

1. Have you experienced any recent hardship such as unemployment, divorce or loss of a family member? Yes or No. If yes, please explain. _____

2. Do you have any barriers to communication such as hearing impairment, vision impairment or loss of memory? Yes or No. If yes, please explain. _____

3. Do you have an advanced care plan such as a Living Will or Advanced Directive? Yes or No. If yes, please let us know what you have. _____

4. Do you engage in any unhealthy behaviors that could effect your health such as poor dental hygiene or being around second-hand smoke? Yes or No. If yes, please explain. _____

5. Do you have a family history of physical or substance abuse? Yes or No. If yes, please explain. _____

6. What is your learning preference? Verbal or Written

7. Do you have any learning barriers? Yes or No. If yes, please let us know of your barriers. _____

Date form completed _____

Patient Name _____
Please print name

Patient Signature _____

Reviewed by: _____



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Permission to Disclose Information to Those Involved in My Care

I hereby allow _____

Clinic to disclose the following information. (check all that apply)

This form does not authorize releasing copies of my medical records.

- Appointment times and dates
- Medical information, including my symptoms, diagnosis, medications and treatment plan
- Tests that have been performed
- Test results
- Billing/payment information

Other health information (describe) _____

To the following people who are involved with my healthcare and/or payment information:

(check all that apply and list names and telephone numbers)

- Spouse _____ Phone: _____
- Friend _____ Phone: _____
- Child(ren) _____ Phone: _____
- Other _____ Phone: _____

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail? (circle how you wish to receive messages, and provide the phone number)

- No, DO NOT leave any messages
- Yes, at home, cell phone or work: Home Phone: _____

Cell Phone: _____ Work Phone: _____

- Yes, only at home Home Phone: _____
- Yes, only on cell phone Cell Phone: _____

I understand that in certain situations _____

Clinic may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permission at any time.

Patient Name (please print): _____ Date of birth: _____

Patient/Guardian Signature: _____ Date: _____

If patient is a minor, please complete the following information:

Mother's name/contact number: _____

Father's name/contact number: _____



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FINANCIAL POLICY

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we hear from them. As a courtesy, we accept cash, checks, Visa, Discover, and Master Card.
2. If you have an HMO or PPO insurance with a designated primary care physician, please make sure you have selected a physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.
3. All co-pays must be paid at the time of your service
4. Not all services are a covered benefit in all contracts. If you have a question regarding benefits, you need to call your insurance company prior to your office visit and check your benefits. Your insurance policy is a contract between you and your insurance company.
5. All services must be paid in full within 30 days after your insurance has paid their portion. If your visit is due to a Motor Vehicle Accident, payment in full is due at the time of the service.
6. The person who brings a child for care is ultimately responsible for their bill. The physician will not get involved in court decisions or support disputes.
7. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full
8. All returned checks must be paid with cash or money order within 5 working days or they will be turned over to the prosecuting attorney's office.
9. If you have any questions, please call our billing office at 816-407-4200.
10. All deductibles and co-payments for Obstetric (OB) services must be paid in full by the 7th month with regular payments due each month by cash, check or credit card.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

Patient or Guardian's Signature

Print Patient's Name and Birth Date

Date

*****SIGNATURE ON FILE*****

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to The Kearney Clinic. I permit a copy of this authorization to be used in place of the original. I understand I am financially responsible for all charges whether or not covered by insurance.

Signed: _____ Date: _____

**THE KEARNEY CLINIC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND PATIENT RIGHTS**

By signing this document, I acknowledge that I have received a copy of The Kearney Clinic's Notice of Health Information Practices * and Patient Rights.

Patient Signature: _____ Date _____ Time _____

Patient Name (please print legibly): _____ Date of birth: _____

Patient Representative/Relationship Signature: _____ Date _____ Time _____

Witness: _____ Date _____ Time _____

*Our Notice of Privacy Practices is provided to you at the time of your first visit. Should our privacy practices change, a copy of the current notice is posted in the Clinic's main lobby. You may also request another copy at any time.

The Kearney Clinic Use Only:

If patient acknowledgment was not obtained, please describe reason why below:

Patient refused to sign Acknowledgement.

Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

The Kearney Clinic is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our health information notice. A patient's failure or refusal of this acknowledgement should not interfere with delivery of treatment.

The Kearney Clinic is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines